ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

School Year 2026-2027

Child's picture
Face only

SEVERE ALLERGY Medical Action Plan (MAP)

Name: _____ School: _____

Date of birth: _____ Age: _____

Grade: _____ Teacher: _____

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2026-2027 school year.

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

☐YES ☐NO My child has a history of receiving epinephrine for an allergic reaction.

☐YES ☐NO My child has asthma (If yes, higher risk for a severe allergic reaction).

☐YES ☐NO REQUEST ALLERGEN RESTRICTED LUNCH TABLE

List **ALL** allergies that require a PRESCRIPTION for epinephrine: _____

_____

List all other allergies: _____

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

☐YES ☐NO If my child is to self-carry, as authorized and allowed by a licensed health care provider, I will supply the school with back up epinephrine.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

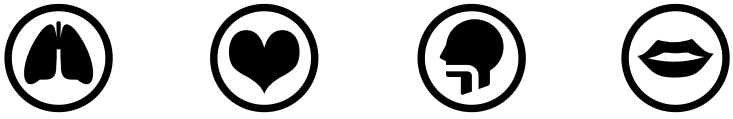
THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips



SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

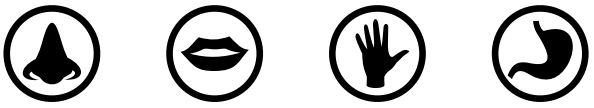
OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **ADMINISTER EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM (intramuscular) ☐ 0.15 mg IM ☐ 0.3 mg IM ☐ 1 mg IN (intranasal) ☐ 2 mg IN

Antihistamine Brand or Generic: Use medication authorization form

Antihistamine Dose: Use medication authorization form

Other (e.g., inhaler-bronchodilator if wheezing): Use medication authorization form

☐ Patient may self-carry ☐ Patient may self-administer

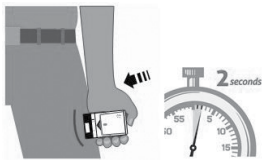
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 4/2025

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

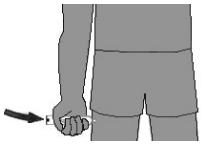
FARE
Food Allergy Research & Education

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO



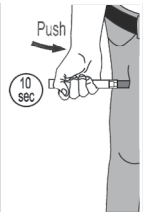
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS



1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS



1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES



1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)



1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

ROCHESTER COMMUNITY SCHOOLS
Authorization for Medication Administration
School Year: 2026-2027

Student name: _____ Date of birth: _____ Grade: _____

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM

(Michigan law and district policy require written authorization for a student to take any medication during the school day).

Name of medication: _____ Reason for medication: _____

Dose (***please do not give a range***): _____ ☐ MG ☐ MG/ML ☐ ML ☐ MCG ☐ UNITS ☐ OTHER: _____

_____

Route: ☐ Oral ☐ Injection ☐ Inhalation ☐ Intra-nasal ☐ Rectal ☐ Topical ☐ Transdermal (Patch) ☐ Other: _____

☐ Routine time(s) to be given: ☐ _____ AM ☐ _____ PM ☐ Other: _____

☐ Frequency: ☐ Daily ☐ Other (*please be specific*): _____

☐ As needed (PRN), (***absent clear and objective criteria, medication cannot be administered during the school day***):

_____

_____

Special instructions or side effects: _____

Student is both capable and responsible for self-administering this medication (***applicable ONLY to high school students***):
☐ No ☐ Yes- supervised ☐ Yes- unsupervised

Student may self-carry an inhaler (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable
Student may self-carry epinephrine (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable

START: ☐ Date from received ☐ Other date/duration (please be specific): _____
STOP: ☐ End of school year ☐ Other date/duration (please be specific): _____

☐ For episodic/emergency events only

Prescriber Name: _____ Signature: _____ Date: _____

Clinic/Hospital Name: _____ Address: _____

Phone number: _____ Fax number: _____

To be completed by Parent/Legal Guardian

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage. I acknowledge that I am required to immediately inform the District of any changes to the healthcare provider's administration instructions. Authorization also includes permission for school personnel and health care provider to contact each other, if needed. I request and authorize the following (***check appropriate direction below***):

☐ School personnel store and administer medication to the above-named student, as authorized by prescriber.
☐ School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: _____ Signature: _____ Date: _____

ROCHESTER COMMUNITY SCHOOLS
Authorization for Medication Administration
School Year: 2026-2027

Student name: _____ Date of birth: _____ Grade: _____

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM

(Michigan law and district policy require written authorization for a student to take any medication during the school day).

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Dose (***please do not give a range***): _____ ☐ MG ☐ MG/ML ☐ ML ☐ MCG ☐ UNITS ☐ OTHER: _____

_____

Route: ☐ Oral ☐ Injection ☐ Inhalation ☐ Intra-nasal ☐ Rectal ☐ Topical ☐ Transdermal (Patch) ☐ Other: _____

☐ Routine time(s) to be given: ☐ _____ AM ☐ _____ PM ☐ Other: _____

☐ Frequency: ☐ Daily ☐ Other (*please be specific*): _____

☐ As needed (PRN), (***absent clear and objective criteria, medication cannot be administered during the school day***):

_____

_____

Special instructions or side effects: _____

Student is both capable and responsible for self-administering this medication (***applicable ONLY to high school students***):
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START: ☐ Date from received ☐ Other date/duration (please be specific): _____
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☐ School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: _____ Signature: _____ Date: _____

ROCHESTER COMMUNITY SCHOOLS

Medication Procedures

(as per standard school policy)

- Medication authorization is for the current school year only and will expire at the end of the school year.
- Only one medication per form. A separate form is required for each medication, each school year.
- Written authorization with medication order completed, signed by the student's authorized healthcare provider and a parent/guardian, is required before any medication can be given at school. Medications include prescription, and non-prescription over-the-counter, including but not limited to: homeopathic, herbal, vitamin, mineral preparation, topical creams or ointments, eye or ear drops, transdermal patches, nasal sprays or mists.
- Medication administration during school hours will be permitted only when failure to do so will jeopardize the health of a student, or the student would not be able to attend school if the medication or treatment were not available during school hours. Parents/legal guardians are urged to administer medication at home and on a schedule, other than school hours, if possible.
- Medication must be brought to school by the student's parent/legal guardian, unless the student has been authorized to self-carry the medication. The district reserves the right to determine that a student may not self-carry for any reason.
- Medication must be administered by an adult in the presence of a second adult, unless the medication is administered by a licensed registered professional nurse or there is an emergency that threatens the student's life or health.
- Parent/legal guardian will ensure that an adequate amount of medication is on hand at the school for the duration of the student's need to take medication, and responsible for checking the need for refills, including expired medications, and replenishing medication to the school in a timely manner.
- All medication must be in a container as prepared by a pharmacy, authorized healthcare provider, or pharmaceutical company, and clearly marked with the student's name, the name of the medication, the prescribed dose, time and frequency of medication administration and special instructions, if any.
- All controlled substance medication will be counted and recorded in the presence of the parent/legal guardian when brought to school.
- Changes in dosage, frequency, or time of administration cannot be made without written instruction from an authorized healthcare provider.
- Designated staff will be responsible for storage, administering medication and notifying parent/legal guardian, in the event that a student refuses medication.
- Medication left over at the end of the school year, or after a student has left the district shall be picked up by the parent/legal guardian. Any medication not retrieved by the parent/legal guardian will be properly disposed of within 7 days of the last student day of school and documented by the individual who is responsible for administering medication.