



Anchorage School District

Allergy/Anaphylaxis Care Plan



Student:	DOB:	Grade:	Student ID:
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Hx of Condition

Oral Allergy Trigger(s)	KNOWN:
	SUSPECTED:
Anaphylaxis Trigger(s)	KNOWN:
	SUSPECTED:
Hx of Asthma (<i>increases the risk of having a more severe reaction</i>): ☐ Yes ☐ No	
Student can self-carry and administer EpiPen: ☐ Yes ☐ No	

Medical Provider Orders

Symptoms	Treatment *Guidelines adopted from AAFA Allergy/Anaphylaxis Plan
Oral Allergy Syndrome	Give these medications
Student has <i>any</i> of these mild symptoms ▪ Mouth: mild itchiness, tingling, or swelling of lips/tongue ▪ Skin: mild hives, itchy rash, or swelling of face	☐ Any available PO antihistamine per package instructions. ☐ Other: <i>Monitor for 30 minutes. If student develops a second symptom, or symptoms worsen, or do not improve move to Red Zone and contact parent/guardian.</i>
Red Zone	Give these medications and CALL 911
Student has <i>any</i> of these symptoms ▪ Mouth: swelling of lips/tongue ▪ Throat: tightening, hoarseness ▪ Skin: swelling of face, cyanotic, pale ▪ Gut: nausea, vomiting, diarrhea, cramps ▪ Lungs: dyspnea, repetitive coughing, wheezing ▪ Heart: thready pulse, low BP, faint ▪ Neuro: altered mental status, dizzy, unconscious ▪ Student Specific:	☐ EpiPen 0.15 mg IM may repeat Q5min if symptoms persist or resolve and then return. ☐ EpiPen 0.30 mg IM may repeat Q5min if symptoms persist or resolve and then return. ☐ Any available PO antihistamine per package instructions for persistent skin, nasal, or ocular symptoms following epinephrine. ☐ Other:
Additional Orders/Notes	

Medical Provider:	NPI:	Phone:
Signature:	Email:	Date:



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Parent/Guardian Authorization

I request that the medication(s) and allergy/anaphylaxis protocols listed on this plan be provided to my child. I will provide needed medications or supplies for care in school. In the absence of the nurse, I expressly authorize other trained Anchorage School District ("ASD") personnel to administer this medication. I agree to defend and hold school district employees harmless from any liability for the results of the care, or the way it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and the school district as part of the provision of my child's care. I agree for the nurse to share health information with school staff on a need-to-know basis for my child's safety and to foster academic success. I understand that this medication(s) will be disposed of at the end of the school year unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar.

Name:	Phone:
Signature:	Date:

This authorization expires at the end of the current school year.

Student Self-Carry Agreement

It is indicated within the Medical Provider Orders of this Allergy/Anaphylaxis Care Plan that I may self-carry medications. I have been trained in the use of my emergency medication. I understand the signs and symptoms of an allergic reaction and agree to always have my medication available. I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) IMMEDIATELY if my medication does not help with my symptoms. I will not share my medication with other students or leave my medication unattended. I will use my medication only for the prescribed purpose.

Name:	Student ID:
Signature:	Date: