SCHOOL DISTRICT OF WISCONSIN DELLS
CONNECT • INSPIRE • ACHIEVE
Everyone. Every day.

School Year: 2026-2027
WDHS ( ) WDMS ( ) WDES ( )

ALLERGY ACTION PLAN & MEDICATION CONSENT

Student: _____ **DOB:** _____ **Grade:** _____

Healthcare Provider: _____ **Phone:** _____ **Fax:** _____

Parent/Guardian: _____ **Phone:** _____ **Alt:** _____

ALLERGIC TO: _____ **History of Asthma:** ( ) YES ( ) NO

ANY SEVERE SYMPTOMS • **Lung:** Wheezing, short of breath • **Throat/Mouth:** Tight, swollen tongue • **Heart:** Pale, blue, dizzy, faint, weak pulse • **Gut/Skin:** Severe vomiting or diarrhea, many hives • Or a MIX of mild symptoms together	1. **GIVE EPINEPHRINE IMMEDIATELY** (note time given) 2. **CALL 911** 3. Lay flat, raise legs 4. **GIVE INHALER NOW, if ordered** 5. Repeat Epi in 5 minutes if symptoms worsen or do not improve 6. Contact parent/guardian
MILD SYMPTOMS ONLY • **Nose:** Itchy, runny, sneezing • **Mouth/Skin:** Itchy mouth, a few hives • **Gut:** Mild nausea / discomfort	1. **GIVE ANTIHISTAMINE** 2. Stay with student & watch closely for changes 3. Contact parent/guardian 4. If symptoms spread or worsen, **GIVE EPI & CALL 911!**

MEDICATION AUTHORIZATION:

EPINEPHRINE: ☐ **Auto-Injector** ☐ 0.15mg (33-66 lbs) ☐ 0.3mg (> 66 lbs) | ☐ **Nasal Spray** ☐ 1mg (33-66 lbs) ☐ 2mg (> 66 lbs)

ANTIHISTAMINE: ☐ **Benadryl**: ____ mg ☐ **Zyrtec**: ____ mg ☐ **Claritin**: ____ mg **Route:** Oral **Instructions:** _____

INHALER: Name: _____ **Dose:** _____ **Instructions:** _____

Do not depend on antihistamines or inhalers. When in doubt, give epinephrine & CALL 911

PARENT/GUARDIAN CONSENT: (Review each item before signing)

- **Delivery & Packaging:** A parent/guardian must deliver and pick up all medication in its original, dated, properly labeled container. (tip: request an extra pharmacy label for all medications supplied to the school).
- **Emergency Self-Carry Only:** Students are strictly prohibited from carrying any medication unless it is a life-saving emergency device (Inhaler & Epinephrine) as authorized below by their healthcare provider.
- **Timeline & Updates:** This authorization is valid for the current school year only. Any dosage or medication adjustments require a new provider order and written notification.
- **Med Administration:** I authorize school personnel to administer this medication and understand that non-medical, trained school staff may perform this duty.
- **Information Sharing:** I authorize school personnel to exchange information verbally, in writing or electronically with school personnel and/or my child's healthcare provider regarding this allergy action plan, medication or the conditions for which it is prescribed.
- **Activities & Travel:** I am responsible to assure that backup rescue medication is available to my child outside of school hours, during travel, and at extracurricular events.
- **Liability Waiver:** I agree to hold the School District of Wisconsin Dells, its employees & agents who are acting within the scope of the duties harmless in any & all claims arising from the administration of this medication.

FOR EMERGENCY MEDS ONLY: (Student May Self-Carry/Self-Administer)

( ) Yes ( ) No **Epinephrine** ( ) Yes ( ) No **Inhaler**

My signature indicates that I approve this allergy action plan & have fully read and understand the above information.

_____ _____

Signature of Parent/Legal Guardian **Date** **Phone Number**

HEALTHCARE PROVIDER ORDER & AUTHORIZATION:

I approve this allergy action plan & authorize the medication above to be administered during the school day in accordance with the above written instructions. I agree to exchange information verbally, in writing or electronically about the student/medication/condition for which it is prescribed. I understand that non-medically trained school personnel may administer this medication.

FOR EMERGENCY MEDS ONLY: (Student May Self-Carry/Self-Administer & has been fully instructed):

( ) Yes ( ) No **Epinephrine** ( ) Yes ( ) No **Inhaler**

_____ _____

Signature of Licensed Healthcare Provider **Date** **Clinic**