Anaphylaxis Medication and Action Plan

Revised 2026

This form is valid for the current school year: 20_____ - 20_____

Student Information

Student Name: _____ Date of Birth: _____ Student ID#: _____

Grade: _____ History of Asthma: No____ Yes _____ (higher risk for severe reaction)

Allergy: To be completed by Physician

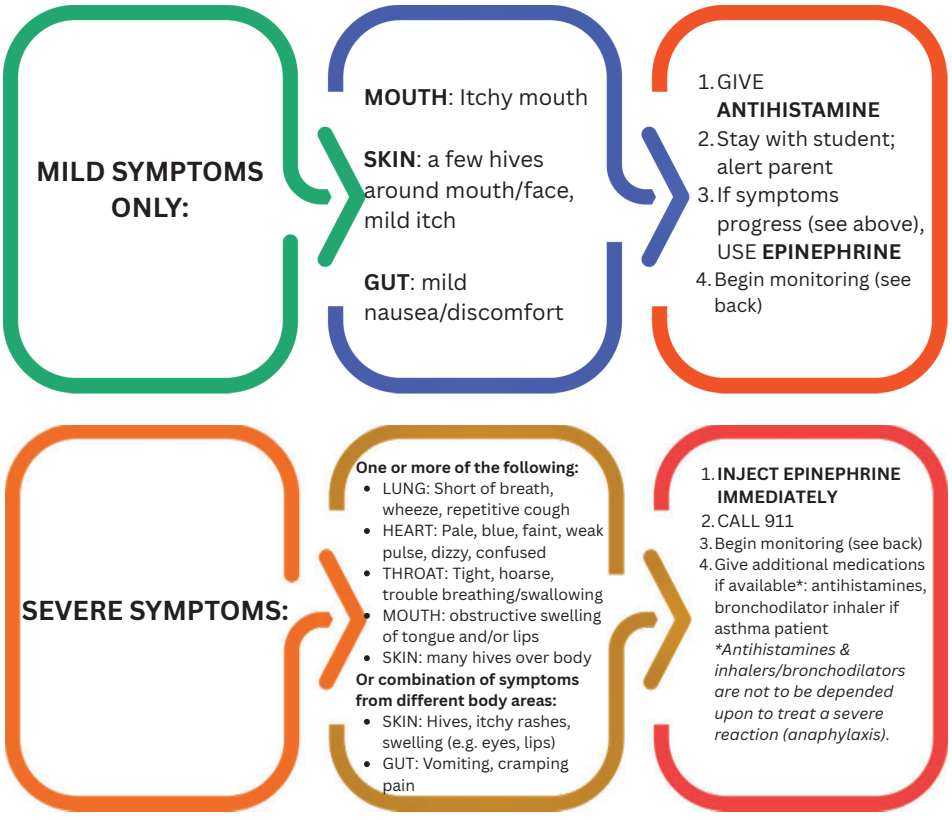
Check all that apply:

- ☐ Foods (list): _____
- ☐ Medications (list): _____
- ☐ Stinging Insects (list): _____
- ☐ Latex: Type I (anaphylaxis)_____ or Type IV (Contact dermatitis)_____

Medication and Dosages

- ☐ **Epinephrine** autoinjector brand: _____ Dosage prescribed: _____mg
- ☐ **Antihistamine**: diphenhydramine/Benadryl _____mg or _____ml to be given by mouth if able to swallow
- ☐ **Other** (name & dose) :_____

Anaphylaxis Action Plan



- ☐ Call 911 if epinephrine is administered
- ☐ Call parent/guardian to notify of reaction, treatment, and student's health status
- ☐ Administer second autoinjector if: _____

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Authorization

Physician Authorization:

I authorize the administration of the above-named medications/treatments to this student during school hours.

Physician Signature: _____ Date: _____

Physician Name (printed): _____ Physician Phone: _____

Parent/Guardian Authorization:

My signature below indicates that I request GPISD staff or contracted outside agency staff to administer the medications/treatments specified above to my child, and I am giving permission for GPISD staff or contracted outside agency staff to contact the physician for additional information, if needed. *Mi firma a continuación indica que solicito al personal de GPISD o al personal externo contratado de la agencia que administre la medicación indicada para mi hijo(a), y le estoy dando permiso para el personal PISD o contratada fuera del personal de la agencia en contacto con el médico para información adicional, si es necesario.*

- ☐ I have provided the school with the correct medication/dosage in its original container.
- ☐ I understand a new form is needed for all changes in medication, dose, or time.
- ☐ I understand all medication shall be brought to the school by a parent/guardian or responsible adult.
- ☐ Unless otherwise specified, this order is valid for the entire school year including summer session if applicable.
- ☐ Expired and discontinued medication not picked up by the last day of school will be destroyed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (printed): _____ Phone: _____

Medication Inventory Record

Date	Amount Received (count with parent/adult)	Signature of Person Bringing Medication	Signature of School Employee Receiving Medication	Expiration Date

Date	Amount Returned	Signature of Person Medication Returned to	Signature of School Employee Receiving Medication	Comments