Valdez City Schools
PO Box 398
1112 West Klutina – Valdez, AK 99686
Telephone (907) 835-4357
Fax (907) 835-4964

ALLERGY/ANAPHYLAXIS CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

Systemic Allergic Reaction/Anaphylaxis Trigger(s): _____

_____

☐ **YES** ☐ **NO** **Does this student have asthma?** *Having asthma increases the risk of having a more severe allergic reaction.

☐ **YES** ☐ **NO** **Is this student able to safely carry an Epinephrine auto-injector on their person during school hours?**
(If this student is not able to self-treat, a nurse or trained adult may administer Epinephrine auto injector)

STUDENT'S SYMPTOMS LIST:

☐ Hives ☐ Scratchy throat ☐ Itching ☐ Rash ☐ Nasal Congestion ☐ Watery or itchy eyes
☐ Abdominal pain or cramping ☐ Pain or tightness in the chest ☐ Diarrhea ☐ Wheezing or coughing
☐ Swelling of the eyes, face, or tongue ☐ Heart palpitations or racing ☐ Dizziness ☐ Nausea or vomiting
☐ Difficulty swallowing or talking ☐ Sense of impending doom ☐ Unconsciousness ☐ Shortness of breath

☐ Other _____

MEDICAL PROVIDER AUTHORIZATION
(Provider have parent/guardian sign Authorization & Agreement page 2-2)

ALLERGY/ANAPHYLAXIS REACTION SYMPTOMS

- Itching nose or mouth
- Sneezing
- Hives (itchy red spots on the skin)
- Scratchy throat
- Rash
- Nasal congestion (known as rhinitis)
- Watery or itchy eyes

- Shortness of breath
- Wheezing or coughing
- Difficulty swallowing or talking
- Nausea or vomiting
- Diarrhea
- Abdominal cramping or pain
- Flushing of the face

- Swelling of the face, eyes, or tongue
- Heart palpitations or racing
- Dizziness (vertigo) / lightheadedness
- Pain or tightness in the chest
- Sense of impending doom
- Unconsciousness

MEDICATION	DOSE	ROUTE	NOTES
☐ Any available antihistamine	Per package	Oral	For milder symptoms
☐ Epinephrine auto-injector	0.15 mg	IM Injection	For more symptoms and/or anaphylaxis
☐ Epinephrine auto-injector	0.3 mg	IM Injection	For more symptoms and /or anaphylaxis
☐ Other_____			

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

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PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

I request that the medication(s) selected and allergy/anaphylaxis protocols listed on this plan be provided to my child. **I will provide needed medications or supplies for care in school.** I understand that, in the absence of the nurse, other trained Valdez City School District (VCS) personnel may administer this medication.

Employees and agents of the Valdez City School District (VCS) strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless VCS from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify VCS immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and VCS as part of the provision of my child's care. I agree for the nurse to share health information with VCS staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining 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 VCS school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

Prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.

STUDENT SELF-CARRY AGREEMENT

I have been trained in the use of my Epinephrine auto-injector and allergy medication. I understand the signs and symptoms of an allergic reaction and agree to have my Epinephrine auto-injector available at all times. I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) IMMEDIATELY if I use my Epinephrine auto-injector. I will not share my medication with other students or leave my medication unattended. I will use my allergy medication only for the prescribed purpose.

STUDENT NAME (PRINTED)	
STUDENT SIGNATURE	DATE

NURSE PLAN REVIEW AND STAFF TRAINING

I have reviewed the *Allergy/Anaphylaxis Care Plan* for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE