Lomira School District

ALLERGY ACTION PLAN

Students Name:	DOB:	**ALLERGY:**
School Year:	Grade:	Bus Student: Yes No
Parent/Guardian:	Daytime Phone:	

Symptoms:	**Give Checked Medication**: **** (To be determined by physician authorizing treatment)	
• If a food allergen or bee sting has occurred but no symptoms:	( ) Epinephrine	( ) Antihistamine
• Mouth: Itching, tingling, or swelling of lips, tongue, mouth	( ) Epinephrine	( ) Antihistamine
• Skin: Hives, itchy rash, swelling of the face or extremities	( ) Epinephrine	( ) Antihistamine
• Gut: Nausea, abdominal cramps, vomiting, diarrhea	( ) Epinephrine	( ) Antihistamine
• Throat*: Tightening of throat, hoarseness, hacking cough	( ) Epinephrine	( ) Antihistamine
• Lung*: Shortness of breath, repetitive coughing, wheezing	( ) Epinephrine	( ) Antihistamine
• Heart*: Thready pulse, low blood pressure, fainting, pale, blue	( ) Epinephrine	( ) Antihistamine
• Other*:	( ) Epinephrine	( ) Antihistamine
• If reaction is progressing (several of the above affected), give:	( ) Epinephrine	( ) Antihistamine

***Potentially life-threatening. The severity of symptoms can quickly change.**

EMERGENCY PROCEDURE:

1. Give appropriate medication as checked below.
2. If self-administered, student must notify school personnel.
3. If Epipen given **Call 911:** State that an allergic reaction has been treated, and additional epinephrine may be needed.
4. Lay student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
5. If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 min or more after last dose.
6. Dr. _____ at _____
7. Emergency contact: Name/Number/Relationship to student

_____ / _____ / _____

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

For completion by Physician:

DOSAGE

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: give:medication/dose/route_____

Other: give:medication/dose/route_____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Possible Side Effects:_____

( ) I have instructed this student in the proper way to use his/her injected medications. It is my professional opinion that he/she should be allowed to carry and use this injected medication by him/herself.

( ) It is my professional opinion that this student should ***NOT*** carry and use his/her injected medication by him/herself.

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.

I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I further agree to hold the Lomira School District, and its employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

( ) Yes ( ) No Authorization hereby granted to release this information to appropriate school personnel and teachers.

Physician Signature:	**Date:**
Parents Signature:	**Date:**