FOR OFFICE USE: School Year: _____ Notified/Copy Given To: Classroom Teacher: _____ Teacher Initials: _____
Classroom restrictions: _____ Class letter provided: _____ # of Epi-pens provided: _____ Exp. Date _____

Anaphylaxis Action Plan & Authorization for Epinephrine & Antihistamine

Section 1: For Parent/Guardian to complete

Student's Name: _____

Birthdate: _____ Grade/Teacher: _____ School: _____

Parent/Guardian: _____ Contact #: _____

Emergency contact (other than parent/guardian): _____

Emergency contact #: _____ Preferred Hospital: _____

Allergic to: _____

Does the student have asthma? Yes* or No **circle one** *Higher risk for severe reaction

Date of last allergic reaction: _____ Describe what happened: _____

Allergy affected by type of exposure: **Please circle those that apply.**
Ingestion (eating) Direct Contact (touch) Inhalation (in the air) Bites/stings Other: _____

1. Is the child able to monitor and prevent his/her own exposures? **circle one** YES NO

2. Does this child:
   - Tell an adult immediately after exposure? YES NO
   - Tell peers and adults about the allergy? YES NO
   - Know what foods to avoid? YES NO Not Applicable
   - Ask about food ingredients? YES NO Not Applicable
   - Read and understand food labels? YES NO Not Applicable
   - Firmly refuse a problem food? YES NO Not Applicable

3. Has this child ever self-administered their emergency medication? YES NO
4. Will this child have an antihistamine at school? YES NO

Has epinephrine ever been administered to this child for this allergen? YES NO
If "yes", please explain: _____
What Symptoms were present? _____
How did the child respond? _____

Section 2: For Healthcare Provider to complete (continued on back page)

Epinephrine and Antihistamine Authorization

Epinephrine: give _____
Medication/dose/route

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

Continue on back page

Section 2: For Healthcare Provider to complete (continued)

1. Student has been instructed and may administer his/her own epinephrine:
   Yes ☐ *student signature required on page 3 No ☐
2. School personnel needs to administer or help child administer epinephrine:
   Yes ☐ No ☐
3. If student has ingested the food allergen or has been stung by the allergen, but NO SYMPTOMS are present then (check all that apply):

   ☐ Administer Antihistamine ☐ Administer Epinephrine

   ☐ Monitor student and treat according to the development of the following symptoms:

Other instructions for school personnel:

_____

Healthcare Providers name printed:_____

Healthcare Providers Signature: _____ **Date:** _____

Section 3: School Action Plan: Steps for School Personnel

1. Retrieve epinephrine auto-injector which will be located here: **(circle below)**
   Office Classroom Child's Backpack Other: _____
2. Give medication as ordered by Health Care Provider
3. Follow steps below based up symptoms
4. Call 911 if epinephrine is given
5. Call parent/guardian
6. An adult trained in CPR is to stay with student to monitor and begin CPR if necessary
7. After epinephrine administration, student may experience a rapid heartbeat, anxiousness or develop a headache

MILD SYMPTOMS ONLY:
Mouth: Itching or tingling to the mouth or face

Skin: A few hives around mouth/face, mild itch or tingling. Hives, redness or welts without generalized swelling.

1. Give Antihistamine (if prescribed)
2. Stay with student; contact parent or guardian
3. If symptoms worsen (see below) USE EPINEPHRINE
4. Monitor student

ANY SEVERE SYMPTOMS:
Lungs: Short of breath, wheeze, persistent cough, difficulty talking
Heart: Pale, blue, faint, weak pulse, dizzy, confused
Throat: Tight, hoarse, trouble breathing/swallowing
Mouth: Obstructive swelling (tongue and/or lips)
Skin: Many hives over body

Or **combination** of symptoms from different body areas:
Skin: Hives, itchy rashes, swelling (e.g. eyes, lips)
Stomach: Vomiting, diarrhea, cramping pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 & parent/guardian
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Inhaler, if asthma

** Antihistamines & inhalers are not to be depended upon to treat a severe reaction. USE EPINEPHRINE.

Monitoring after administration of epinephrine:
Stay with student; call 911 & parent. Tell emergency responders epinephrine was given. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student on back with legs raised. Treat student even if parents cannot be reached.

Section 4: Parent Authorization and Consent

PARENT CARE AUTHORIZATION

- I give permission to Dickinson Public School personnel to administer the above-named medication(s) to my child as directed by my health care provider.
- I understand school personnel will make a good faith effort to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- I understand that if epinephrine is given, 911 will be called and Dickinson Public School district will not be held responsible for any financial costs.
- I will notify the school immediately of any changes in my child's health status or medication.
- I give permission to school personnel to contact my child's physician as needed and that medical/health information may be shared with staff who need to know.

Parent/Guardian Signature of Approval (Required): _____ Date: _____

Form valid for one school year. Please note that new "authorization" forms must be completed prior to the start of each new school year.

SELF-ADMINISTRATION AUTHORIZATION

** ONLY COMPLETE IF YOUR CHILD WILL BE ADMINISTERING THEIR OWN MEDICATION**

☐ I request permission for and authorize my child to self-administer this medication during school hours and district-sponsored activities as needed. I also acknowledge and understand the following: Dickinson public school personnel will not be responsible for the administration of this medication and may not monitor my child's failure to self-administer it. My child and I shall be solely responsible to ensure the medication is taken as prescribed. In exchange for granting my request to permit my child to self-administer this medication, I agree: 1) To indemnify, defend and hold harmless the Dickinson Public School District, its officers, employees and all other individuals working in their official capacities on behalf of the District from any claim or liability for injuries or damages resulting from the self-administration or the above named medication; and 2) To acknowledge that I will not seek any recovery from the District for any claim or liability for injury or damages, including without limitation reasonable attorney fees and costs, caused or claimed to be caused by the self-administration of the above-described medication.

Parent/Guardian Signature of Approval (Required): _____ Date: _____

As the student, I understand the condition this medication is for & training provided by my healthcare provider. I acknowledge I can be disciplined according to district policy for any misuse of this medication.

Student Signature of Approval (Required): _____ Date: _____