MADISON COUNTY SCHOOLS

Life-Threatening Allergy Action Plan

School Year

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Local Physician / Healthcare Provider	Phone:	

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

ALLERGY TO:

Asthmatic ☐ Yes* ☐ No * Higher risk for severe reaction

STEP 1: TREATMENT

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

SYMPTOMS:

GIVE CHECKED MEDICATION

● If a food allergen has been ingested, 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, blueness	☐ Epinephrine	☐ Antihistamine
● Other†	_____	☐ Epinephrine	☐ Antihistamine
● If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

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

MEDICATION DOSAGE & ROUTE

Antihistamine:

Dose: _____

Epinephrine:

Inject epinephrine in thigh using (check one):

☐ Adrenaclick (0.15 mg) ☐ Adrenaclick (0.3 mg)

☐ EpiPen Jr (0.15 mg) ☐ EpiPen (0.3 mg)

Epinephrine Injection, USP Auto-injector- authorized generic

☐ (0.15 mg) ☐ (0.3 mg)

☐ Other (0.15 mg) ☐ Other (0.3 mg)

Other: _____

(PRINTED NAME OF PHYSICIAN) (SIGNATURE OF PHYSICIAN / DATE)

THIS SECTION IS TO BE COMPLETED BY PHYSICIAN

STEP 2: EMERGENCY CALLS

911 CALL REQUIRED UPON EPI PEN DELIVERY.
NOTIFY Parent/Guardian of all allergic reactions and treatment.

❶ **Call 911** . State that an allergic reaction has been treated, and additional epinephrine may be needed.

❷

Emergency Contact Person:	Contact Phone(s):

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

Parent/Guardian Signature _____ **DATE** _____

MADISON COUNTY SCHOOLS

School Year

AUTHORIZATION FOR STUDENT TO CARRY AND SELF-ADMINISTER PRESCRIPTION ASTHMA AND/OR ANAPHYLAXIS MEDICATION

☞ *Action Plans are required by law for students diagnosed with Asthma and/or Anaphylaxis Conditions* ☜

Student's Name:		Date of Birth:
School:	Grade:	Teacher:

Diagnosis: _____

Medication / Purpose: _____

Prescribed Dose: _____

TIME: (The times at which or circumstances under which medication may be administered): _____

HEALTH CARE PROVIDER STATEMENT

The student has asthma and/or anaphylaxis and is capable of self-administering the prescription asthma and or anaphylaxis medication. I recommend the student be allowed to carry prescription medication as prescribed.

☛ **Provider's Signature/DATE** _____ ☛ **Printed Provider Name** _____

Telephone: _____ Fax: _____

********** PARENT/GUARDIAN SECTION**********

PARENT/GUARDIAN AUTHORIZATION

I authorize my child/student to carry and self-administer prescription asthma and/or anaphylaxis medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of prescription asthma and/or anaphylaxis medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

☛ **Parent/Guardian Signature/DATE** _____ ☛ **Printed Name** _____

Emergency contact phone number: _____