Physician/Parent Authorization for Anaphylaxis Management
Allergy Action Plan

∗This form is to be renewed at the beginning of each school year.
For children with multiple severe allergies, use one form for each allergy.

Students Name:	**Date:**
Teacher/Grade:	**DOB:**
ALLERGIC TO:	

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

TO BE COMPLETED BY THE PHYSICIAN
The parent/guardian of the above named student has notified the school that this student has a potentially life-threatening allergy and will require an Epipen at school, in the event of an emergency. Please complete this form based on your records and knowledge of this student and sign in the space provided.

♦STEP 1: TREATMENT♦

Symptoms:	**Give Checked Medication**:** **(to be determined by provider authorizing treatment)	
If food allergen has been ingested or allergen has been contacted, 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),	□ Epinephrine	□ Antihistamine

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

DOSAGE
Epinephrine: inject intramuscularly (circle one)
EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for instructions)
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.

♦STEP 2: EMERGENCY CALLS♦

1. Call 911 (or Emergency Medical Services_____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Provider:
_____at_____.

3. Emergency contacts:
Name/Relationship Phone Number(s)
a._____ 1)_____ 2)_____
b._____ 1)_____ 2)_____
c._____ 1)_____ 2)_____

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

FOR SELF-ADMINISTRATION ONLY

Does this student have physician permission to self-administer this medication and to carry this medication on himself/herself? Yes___ No____
Has this student been trained in the signs and symptoms of minor and major reactions? Yes ____ No____
Is this student capable of self-administering Epipen? Yes___ No___
Can this be safely self-administered in the school setting? Yes___ No___
Does this student need the supervision of a designated adult? Yes___ No___
Has the student been trained in the self-administration of the Epipen? Yes___ No___

Physician's Signature: _____ Date: _____
Physician's Name:_____Phone:_____
Address:_____Fax_____

TO BE COMPLETED BY THE PARENT

I, the undersigned, the parent/guardian of _____ request that an Epipen be administered to my child, as prescribed by the physician. I understand that the school administration will designate trained staff to perform this procedure. It is my understanding that in performance of the procedure, the designated person(s) will be using a standardized procedure that has been approved by the physician. I will notify the school immediately if the health status of my child changes, I change physicians, or the procedure is canceled or changed in any way. I also give my consent to release medical/health records and permission for appropriate school staff to contact the physician/health care provider for additional information if needed. THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) SHALL NOT INCUR ANY LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE STUDENT'S TRANSPORT OR SELF-ADMINISTRATION OF MEDICATION, AND THE PARENT/GUARDIAN SHALL INDEMNIFY AND HOLD HARMLESS THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) AGAINST ANY CLAIMS ARISING OUT OF THE TRANSPORT AND SELF-ADMINISTRATION OF MEDICATION.

Parent's Signature: _____ Date: _____

FOR SELF-ADMINISTRATION ONLY

I, the parent/guardian of _____ request that he/she be allowed to self-administer the Epipen. I understand that the school administration will designate trained staff to monitor the procedure. It is my understanding that in performance of the procedure, my child will be using a standardized procedure that has been approved by the physician. THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) SHALL NOT INCUR ANY LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE STUDENT'S TRANSPORT OR SELF-ADMINISTRATION OF MEDICATION, AND THE PARENT/GUARDIAN SHALL INDEMNIFY AND HOLD HARMLESS THE DISTRICT (INCLUDING ITS EMPLOYEES AND AGENTS) AGAINST ANY CLAIMS ARISING OUT OF THE TRANSPORT AND SELF-ADMINISTRATION OF MEDICATION.

Parent Signature:_____Date: _____

TRAINED STAFF MEMBERS

1._____ Room_____

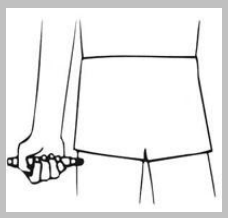
2._____ Room_____

3._____ Room_____

FOR OFFICE USE ONLY

How to Use an Epinephrine Auto-Injector

1. Pull off gray safety cap
2. Place black tip on outer thigh (always apply to thigh)



3. Using a swing and jab motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10.
4. Remove and bend needle back on hard surface. Place back in plastic tube and send EpiPen ® with patient to hospital.

MEMBERS

1. **_____**
2. **_____**
3. **_____**