MISD Allergy/Anaphylaxis Action Plan & Medication Authorization

Student's Name: _____ **ID#**_____ **DOB**_____ **Grade**_____ **Teacher**_____

ALLERGY TO: _____ ☐ **Asthmatic or History of Asthma**

Epi Pen Qty:	**Location:** ☐ Clinic	☐ Trainer/Coach	☐ On his/her person

Medication Treatment for Allergic Reaction:

☐ Antihistamine _____ _____ mg Special Instructions:
☐ Epinephrine Injection _____ _____mg Special Instructions:

Action Plan for Exposure:

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		Epinephrine		Antihistamine
Other:		Epinephrine		Antihistamine

❖ **Potentially life threatening**

Action Plan for Minor Reaction:

Exposure to allergen, but no symptoms		Epinephrine		Antihistamine
Have student resume activities if:				
Contact parent if:				

☐ I hereby authorize _____ to carry and self administer his/her Epinephrine injection medication as prescribed while on school property or school related events.

☐ I do **NOT** authorize _____ to carry and self-administer the above medication while on school property or school related events.

Physician's Name: _____ **Telephone Number:** _____

Physician's Signature: _____ **Date:** _____

☐ **If a parent/guardian cannot be reached, do not hesitate to Call 911/EMS**

Parent/Guardian Signature _____ Date: _____

_____ _____ _____

Parent Telephone | Emergency Contact Name | Emergency Telephone Number

_____ _____

Student Signature (if authorized to carry his/her Epi-Pen medication at school) | Date

☐ Student Demonstrates knowledge of proper use, procedure and school policy regarding the responsibility of carrying medication on his/her person.

_____ _____

Nurse Signature | Date