

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Weight: \_\_\_\_\_ School Year: \_\_\_\_\_

**ALLERGIC TO:** \_\_\_\_\_

Asthma:  No  Yes (higher risk for severe reaction)

History of anaphylaxis?  No  Yes If yes, date of reaction and symptoms: \_\_\_\_\_

**ACTION PLAN TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER**

**SEVERE SYMPTOMS**

**FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:**

- LUNG:** Short of breath, wheeze, repetitive cough
- HEART:** Pale, bluish skin, faint, weak pulse, dizzy, confused
- THROAT:** Tight, hoarse, trouble breathing or swallowing
- MOUTH:** Significant swelling of the tongue or lips
- SKIN:** Many hives over body, widespread redness
- GUT:** Repetitive vomiting, severe diarrhea
- OTHER:** Feeling of "doom"; confusion, altered consciousness or agitation

**MILD SYMPTOMS**

- NOSE:** Itchy or runny nose, sneezing
- MOUTH:** Itchy mouth
- SKIN:** A few hives, mild itch
- GUT:** Mild nausea or discomfort



**WHAT TO DO:**

- **INJECT EPINIPHRINE IMMEDIATELY** into upper outer thigh. It is OK to inject through clothing.
- Call 911. Tell emergency dispatcher the person is having anaphylaxis.
- Call parent.
- Give additional medications, if prescribed (eg Antihistamine, Inhaler).
- Lay the person flat & raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- It is highly recommended to transport to ER, even if symptoms resolve. If parent not available for transport, staff member must ride with student. If parent refuses transport to ER, student will be sent home for the day.

**WHAT TO DO:**

For **MILD SYMPTOMS** from **MORE THAN ONE** body system area, **GIVE EPINEPHRINE**

For **MILD SYMPTOMS** from a **single body system** area, follow direction below:

- Give antihistamine, if prescribed
- Notify Parent
- Watch closely for changes. If symptoms worsen, **GIVE EPINEPHRINE**

**MEDICATIONS/DOSES**

Epinephrine (list type): \_\_\_\_\_ Dose:  0.15  0.30

Antihistamine: \_\_\_\_\_ Dose: \_\_\_\_\_

Other (eg Inhaler if child has asthma): \_\_\_\_\_

Child may carry Epinephrine injector:  Yes  No

Child may give him/herself epinephrine injector:  Yes (physician has instructed on proper use)  No (if child refuses/is unable to self-treat, an adult must give medication)

Physician Name and Signature (required): \_\_\_\_\_ Date \_\_\_\_\_ Phone# \_\_\_\_\_

I have read and agree with above physician orders for my child \_\_\_\_\_  
 Parent Signature Date

**EMERGENCY CONTACT INFORMATION:**

It is the responsibility of the parent/guardian to provide current contact information that includes working phone numbers for parent, guardians and emergency contact persons.

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact relation to student: \_\_\_\_\_

Parents must provide at least one epipen to keep in the Health Room. If the healthcare provider agrees that a student can carry their own epipen, this epipen will be in addition to the one in the Health Room. If a student carries an epipen, the parent agrees that the medication will be carried in a secure, protective container and the medication will be labeled with the student's name. Parent also agrees that the replacement of expired medication is the responsibility of the parent.

In the event of a crisis requiring immediate intervention, a school employee will administer the injection (if the child is not able to do so) or other prescribed drug. The employee will make his or her best effort to comply with the recommended procedure developed by the child's physician. The undersigned understands that the employee administering the prescribed medication may not be a licensed professional. Additionally, the undersigned agrees to hold Portland Christian School and its employees and intervening staff members harmless for any injuries resulting from the emergency care unless the injury was caused by negligence. The parent/guardian further agrees to indemnify and hold harmless Portland Christian School and any employee from any claim resulting from the student's self-administration of medication per state law. **This allergy care plan shall be in effect for the school year in which it is granted and shall be renewed each following school year.**

Parent/Guardian hereby gives consent for the child's medical records and reports to be shared with Portland Christian School and its employees, and for the child's physicians to discuss his/her medical condition referenced above to assist them in planning for my child's care while at school or school events.

Parent/Guardian Signature (mandatory)

Date

**OFFICE USE ONLY**

Care Plan received by: \_\_\_\_\_ Date: \_\_\_\_\_

Medication brought in: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Medication brought in: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Student will carry an additional epipen on self: [ ] Yes [ ] No