ANAPHYLAXIS ACTION PLAN

STUDENT INFORMATION (ATTACH PHOTO TO FORM) Date___________________

Name:____ Date of Birth: __________________________________

Class and Teacher:____

CONTACT INFORMATION

Mother:____________________________________

Home #:____________________________________

Work #: ____________________________________

Cell # : _______________ Email: _______________

Father: ____________________________________

Home #:____________________________________

Work #: ____________________________________

Cell # : _______________ Email: _______________

Physician:___________________________________

Work #: ____________________________________

Cell # : _______________ Email: _______________

MEDICATIONS – To be filled out by physician

The student may take the following anaphylaxis medication at school, on school provided transportation or at school-related events and activities:

☐ Check here if student may carry and self-administer his/her auto-injectable epinephrine.

☐ Check here if student will not carry and auto-injectable epinephrine, but will be kept in nurse's office.

Name of Medication: ___________________________

Purpose of Medication: _________________________

Dosage:____________________________________

Time/Circumstances Medication should be given:_____

____

Time period for which Medication is Prescribed:_____

____

FIRST AID

The following are specific instructions to be followed should the student have an anaphylaxis event:_______

____

____

☐ It is my professional opinion that the student should be immediately transported to a medical treatment facility at which additional observation and care may be provided whenever a significant allergic reaction is believed to have occurred.

PREVENTION

The following allergens or irritants are particularly bothersome to the student:________________________

____

SYMPTOMS

The following are symptoms that may indicate the onset of an anaphylaxis event:____________________________

____

PARENTAL PERMISSION & RESPONSIBILITIES

I, Parent/Legal Guardian of the above named student, understand and agree to the conditions of the school policy and the action plan. I permit the school to seek emergency medical treatment for the student when deemed necessary, perceived appropriate or as directed above by the physician.

If Student may administer medication:

☐ I give authorization for self-administration and possession of anaphylaxis medication by my child while on school property, on school provided transportation, or at a school related event or activity, while under supervision of school personnel, and while in before school and/or after school care on school-operated property. My child demonstrates a full understanding of the proper use of his/her auto-injectable epinephrine.

I take sole responsibility for:

- Monitoring the anaphylaxis medication use, and refilling of prescriptions for anaphylaxis medication;
- Ensuring the student always carries his/her auto-injectable epinephrine on his/her person;
- Deciding if backup medication will be kept at the school, and providing the school with the backup medication;
- Informing school staff in writing of any changes in the student's treatment or anaphylaxis management or changed medical information; and
- Informing school staff in writing of any medication side effects that the school should notify me about if they occur.

I release and agree to hold the School District and its employees and agents harmless from liability for an injury arising from the student's possession and/or self-administration of auto-injectable epinephrine while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct

Parent Signature: ________________________________

Date: ____

STUDENT AGREEMENT

I, ________________________________, understand and agree to the terms of the anaphylaxis action plan.

If student is self-administering medication:

☐ I have been instructed in the proper use of my prescription auto-injectable epinephrine and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstances.

Student Signature: ________________________________

Date: ____

PHYSICIAN APPROVAL

I agree with the above anaphylaxis action plan, including the name, purpose, dosage, and administration directions of the auto-injectable epinephrine

If student is self-administering medication:

☐ It is my professional opinion that the student should be permitted to carry and self-administer his/her auto-injectable epinephrine . The above-named student has been instructed in, and demonstrates an understanding of, the proper use of his/her auto-injectable epinephrine.

☐ Student will not carry auto-injectable epinephrine.

Physician Signature: ______________________________

Printed Physician Name: ___________________________

Date:____

Address:____

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