Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____

Place Child's Picture Here

ALLERGY TO:_____

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

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**:	
▪ If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
▪ Other †	_____	☐ EpiPen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

To be determined by physician authorizing treatment

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ 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!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

GRAFTON PUBLIC SCHOOLS

ALLERGY INFORMATION

_____ _____

Students Name Allergy to

Please fill in this form so that we may treat your child if he/she has a reaction while at school. Return to school as soon as possible.

1. Date of last reaction:

2. Type of reaction:

3. Reaction is by: Ingestion _____
   Touching _____
   Inhalation _____

4. Treatment if allergic reaction:

   Epipen Kit in school _____
   Medication by mouth _____ (in school)
   _____ (at home)
   No medication necessary _____

5. Person to notify if child has a reaction:

	Home	Work	Cell
Mother	_____	_____	_____
Father	_____	_____	_____

If your child is to receive medication, please have the attached medication form filled out and signed by both you and your child's physician. Return both forms to school along with the medication in its original container(s).

Parent/Guardian Signature _____ Date _____

Thank You for your prompt response.

School Use Only
Meds received in school: Yes____ No ____

Revised 2-06

Grafton High School Self-Administration Medication Permission Form for Parents

Dear Parent/Guardian:
District policy allows students to self-administer medications with school nurse and parent/guardian approval. In order for your child to carry and administer his/her own inhaler and/or epinephrine auto injector and/or insulin and/or other medication as prescribed by a licensed physician, except controlled substances, you must complete part A of this form. Part B will be completed in the health office with your child. You may be present during the completion of part B of this form if you so desire. Your child must be able to answer the questions in Part B or he/she will not be permitted to carry or administer his/her own medication. This is for the safety of your child and others. This form must be completed IN ADDITION to the parent and prescriber's authorization form for medication administration of medication.

A. To be completed by the parent/guardian:
I request that my child _____ (student name) be permitted to carry on his/her person the following medication that is prescribed for _____ (student name).
Inhaler Name _____
Epinephrine Auto Injector Name _____
Insulin Name _____
Medication Name _____ Medication Name _____

My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child understands that if he/she self administers this medication while at school that he/she will inform the school nurse or closest adult immediately. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the agreement in Part B.
Parent/Guardian Signature: _____ Date: _____

B. To be completed by the school nurse:
Yes _____ No _____ Student is consistently able to:
- Name the medication;
- Identify the correct medication;
- Explain the purpose of the medication;
- Knows the correct dosage;
- Explain when the medication is to be taken;
- Describe what will happen if the medication is not taken;

Yes _____ No _____ Student demonstrated the correct use/administration.
Yes _____ No _____ Student realizes his/her responsibility in carrying his/her own medication(s) and agrees not to share the medication(s) with others.
Yes _____ No _____ The student agrees to notify the school nurse or closest adult immediately after self-administering his/her medication during school hours or on school-sponsored trips.
Yes _____ No _____ The student agrees to come to the health office immediately upon taking the prescribed medication or with any questions, concerns or adverse side effects.

The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.

Student Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

JLCD-E MEDICATION PERMISSION FORM

As a general school procedure, no medication will be dispensed at school except absolutely necessary medications. Examples of emergency medications are those required for diabetic reactions, asthma attacks and bee sting allergies. A medication permission form is required for emergency medication. Other medications are to have their time schedules arranged by your family doctor so as to avoid being given during school hours. These include medicines required three or four times a day. If prescribed medications must be taken three or four times each day and cannot be given at home only, a medication permission form signed by the physician and parent is required.

Medication dispensed at school must be kept in the original pharmacy container. These medications must be accompanied by a medication permission form which has been signed by the doctor and parent/guardian. Forms are available through the school nurse's office and some area physicians.

Medication for students in grades K-8 must be brought to school by a parent or guardian and must be handed directly to the school nurse. High school students may not bring medication to school without prior approval from the school nurse and parent/guardian. High school students are never allowed to carry narcotics, psychotropic medications or ADD/ADHD medications. High school students must bring the medication in the labeled container directly to the nurse upon arrival to school in the morning. Students in Grades 7-12 may carry their personal inhalers or Epipens only if approved by the school nurse and with a signed medication permission form from the physician with parent/guardian signature.

Medication will be dispensed by the school nurse or delegate, only when absolutely necessary in accordance with the school policy. Only a 30 day supply can be brought to school at one time. Outdated medicine will be discarded unless otherwise instructed by parent/guardian. Medication may be picked up no later than one week after school ends, after which it will be discarded. Each school will be responsible for maintaining current and accurate records of all students seen and action taken.

To be completed by the Physician: The below-named student must: (a) take prescribed medication during school hours, as it is required to be administered more than three times a day and cannot be given at home only, or (b) take prescribed emergency medication.

Student_____ School_____

Diagnosis_____ Medication Prescribed_____Dosage Required_____

Duration of Medication (days) _____Time of Day Medicine to be Administered at School_____

In the event of the following side effects, the physician must be notified: _____, _____, _____, _____ Allergies _____

_____

Additional Comments_____

_____

Date_____Physician's Signature_____ _____Phone_____

Parent/Guardian: I, the undersigned, give permission to school personnel to administer to my child the above-named medication. I understand that school personnel are not responsible for any problems arising from administration of this medication, its side effects (if any) or for the omission of medication. I further agree to indemnify and hold harmless the School Committee and its agents and servants against all claims as a result of any or all acts performed under this authority. In grades 7-12, it is the student's responsibility to report to the nurse's office at the time the medication is to be taken.

YES NO In health unit

YES NO May carry on person (applies to grades 7-12 only)

Date_____ Signature_____Phone_____

SC Reviewed August 20, 2012