Student Anaphylaxis Action Plan and Authorization for Epinephrine and Antihistamine

Child's Name		DOB	Grade
Parent(s)/Guardian(s)		School/Teacher	
Parent/Guardian Phone Numbers: Home:	Work:	Cell:	
Emergency Contact (Other Than Parent/Guardian)		Emergency Phone	
Physician/Phone	Hospital/Phone		

ALLERGY MANAGEMENT INFORMATION

1. **This child is severely allergic to**:____
   Describe what happened when child was first diagnosed with allergy: ______________________
   ____

2. **This child is allergic by the following ways of exposure (*check all that apply*):**
   ☐ Direct contact (touching) ☐ Ingestion (if eaten) ☐ If bitten or stung
   ☐ In the air (inhalation) ☐ Other/please explain:____________________________

3. **Self-Care:**
   a. Is this child able to monitor and prevent his/her own exposures? ☐ Yes ☐ No
   b. Does this child:
      - Tell an adult immediately after an exposure? ☐ Yes ☐ No
      - Wear a medical alert bracelet, necklace, or watchband? ☐ Yes ☐ No
      - Tell peers and adults about the allergy? ☐ Yes ☐ No
      - Know what foods to avoid? ☐ Yes ☐ No ☐ Not Applicable
      - Ask about food ingredients? ☐ Yes ☐ No ☐ Not Applicable
      - Read and understand food labels? ☐ Yes ☐ No ☐ Not Applicable
      - Firmly refuse a problem food? ☐ Yes ☐ No ☐ Not Applicable

   c. Does this child have an emergency medication? ☐ Yes ☐ No
   d. Has this child ever self-administered their emergency medication? ☐ Yes ☐ No
   e. Will this child have an antihistamine at school? ☐ Yes ☐ No

4. **Has epinephrine ever been administered to this child for this allergen?** ☐ Yes ☐ No
   If "yes", explain**:**____
   What symptoms were present?____
   What was the response?____

(**Continued on Back Side**)

SCHOOL ACTION PLAN

a. Retrieve epinephrine auto-injector which will be located here:______________________________
b. Give medication as ordered on Health Care Provider Form 42a
c. Follow Health Care Provider Form 42a
d. Call **911** if epinephrine is given
e. Call parent/guardian
f. An adult trained in CPR is to stay with student–monitor and begin CPR if necessary
g. After epineprhine administration, student may experience a rapid heart rate, anxiousness or develop a headache

PARENT CARE AUTHORIZATION

- I understand that school personnel will make good faith efforts to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- I will notify the school immediately of any changes in my child's health status or medication.
- I give permission to School personnel to contact my child's physician as needed; and that medication/health information may be shared with staff who need to know.
- If I don't provide the required "Healthcare Provider Anaphylaxis Action Plan," I give my consent for Bismarck Public Schools to obtain it from my child's healthcare provider.

Parent/Guardian Signature of Approval (*Required*):_______________________________ Date: ________

EPINEPHRINE AND ANTIHISTAMINE AUTHORIZATION

Please bring this completed form along with your child's medication(s) to school. Medication must be in its original container with label attached – small containers preferred.

Inject into outer thigh (check one): ☐ **Epipen®** ☐ **Epipen® Junior** ☐ **Auvi-Q®** ☐**Adrenaclick®**

Name of antihistamine:____________________________ Strength:_________ Dose:_______________

Time to give at school:____

Instruction for use:____

Medication side effects:____

Other information staff should know about student and these medications:_________________________

____

As parent/guardian of the above-named child, I give permission to Bismarck Public School personnel to administer the above named medication(s) to my child as directed by my health care provider; *I also acknowledge school personnel will not be held legally or financially responsible for the administration of this medication(s).*

Parent/Guardian Signature of Approval (*Required*):______________________________ Date:_________

**** Form valid for one year from date of signature unless there are changes in medical status.***