Allergy Emergency Action Plan

Student Name:_____ **DOB:** _____ **ID Number:** _____

Parent/Guardian (*Padre/Tutor)*_____ Phone (*Teléfono)* _____

Emergency Contact (Contacto de Emergencia) _____ Phone (*Teléfono)* _____

Parent/Guardian Consent to Administer Medications/Autorización de los padres/tutores para la administración de medicamentos

I, the parent/guardian of the named student, request that this action plan be used to guide care for my child and consent to the administration of medications as prescribed by the physician. I agree to: (*Yo, el padre/tutor del estudiante nombrado, pido que este plan de acción sea utilizado para guiar el cuidado de mi hijo y doy mi autorización para la administración de medicamentos según lo recetado por el médico. Estoy de acuerdo con:)*

1. Provide necessary supplies, equipment, and medications. *(Proporcionar los materiales, el equipo y los medicamentos necesarios.)*
2. Notify the school nurse of any changes in the student 's health status and complete a new consent form if any changes in the orders are made from the physician. (*Informar a la enfermera de la escuela de cualquier cambio en el estado de salud del estudiante y completaré un nuevo formulario de consentimiento si hay cambios en las órdenes del médico.)*
3. Authorize the school nurse to communicate verbally and in writing with the student 's health care provider about this condition and corresponding orders/action plans. *(Autorizar a la enfermera de la escuela para que se comunique verbalmente y por escrito con el proveedor de atención médica del estudiante sobre esta condición y las órdenes o planes de acción correspondientes.)*
4. School staff interacting directly with my child may be informed about his/her condition and corresponding medical needs while at school. *(El personal de la escuela que interactúa directamente con mi hijo puede ser informado sobre su condición y sus necesidades médicas correspondientes mientras está en la escuela.)*

_____ _____

Parent/Guardian Signature *(Firma del Padre/Tutor)* **Date *(Fecha)***

To Be Completed by Physician

Student is allergic to : _____

Symptoms: The severity of the symptoms can quickly change and become life-threatening.		**Give Checked Medication**
Mouth	Itching and swelling of the lips, tongue, or mouth	☐ EpiPen ☐ Antihistamine
Throat	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough	☐ EpiPen ☐ Antihistamine
Lungs	Shortness of breath, repetitive coughing and/or wheezing	☐ EpiPen ☐ Antihistamine
Heart	"Thready" pulse, passing out	☐ EpiPen ☐ Antihistamine
Skin	Hives, itchy rash and/or swelling about the face or extremities	☐ EpiPen ☐ Antihistamine
G.I.	Nausea, abdominal cramps, vomiting and/or diarrhea	☐ EpiPen ☐ Antihistamine

Medication Name *(provided by parent/guardian)*	**Dose**	**Instructions**
EpiPen or EpiPen Jr. (circle one)		**Give IM - Refer to package instructions**
Antihistamine:		
Other:		

- Call 911 if EpiPen is used. State that an allergic reaction has been treated, and additional epinephrine may be needed.
- Call Parent/guardian at numbers listed above.

For Emergency Medications

☐ It is my professional opinion that this student **<u>should</u>** carry his/her EpiPen provided the campus nurse determines it is safe and appropriate. The student has been instructed in the proper use of this medication.

☐ It is my professional opinion that this student **<u>should not</u>** carry his/her EpiPen.

Physician Name (printed): _____ Phone number: _____

Physician Signature: _____ Date: _____

This plan is valid for the current school year including summer school unless changes are made