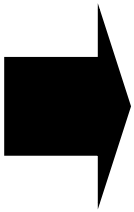
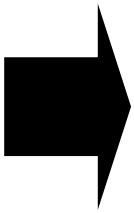
Placentia Yorba Linda Unified School District
Allergy/Anaphylaxis Action Plan

Name: _____ DOB: _____ Grade: _____

Allergy to: _____ School: _____

Asthma: ☐ No ☐ Yes (higher risk for a severe reaction). Please provide separate medication form for inhaler if needed

	Give Checked Medication:** **(To be determined by provider authorizing treatment)
Insect Sting: If child has been stung, but *no symptoms*:	☐ **Epinephrine** ☐ **Antihistamine** ☐ NA
Food Allergy: If a food allergen has been ingested, but *no symptoms*:	☐ **Epinephrine** ☐ **Antihistamine** ☐ NA

Any SEVERE SYMPTOMS (After suspected or known contact)**:** **One or more of the following:** LUNG: Short of breath, wheeze, repetitive cough HEART: Pale blue, faint, weak pulse, dizzy, confused THROAT: Tight, hoarse, trouble breathing/swallowing MOUTH: Obstructive swelling (tongue and/or lips) SKIN: Many hives over body Or **combination** of symptoms from different body areas: SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips) GUT: Vomiting, diarrhea, cramping pain		1. **INJECT EPINEPHRINE IMMEDIATELY** 2. Call 911 3. Give additional medications:* - Antihistamine - Inhaler (bronchodilator) if asthma 4. Alert parent and school nurse *Antihistamines & Inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE
MILD SYMPTOMS ONLY (After suspected or known contact): MOUTH: Itchy mouth SKIN: A few hives around mouth/face, mild itch GUT: Mild nausea/discomfort **If initialed by Provider, GIVE EPINEPHRINE FOR MILD SYMPTOMS. Initials _____**		1. **GIVE ANTIHISTAMINE** 2. Stay with student 3 Alert parent and school nurse 4. **If symptoms progress (see above). USE EPINEPHRINE**

ALLERGY/ANAPHYLAXIS MEDICATIONS/DOSES

Epinephrine (Brand) _____ Side Effects: _____ Amount of time between doses: _____	Dose _____	Route _____
Antihistamine (Brand) _____ Side Effects: _____ Amount of time between doses: _____	Dose _____	Route _____

It is of my professional opinion that this student should be permitted to carry/self administer this emergency epinephrine. This student has been instructed and demonstrates an understanding of proper usage. *Health Care Provider Initials* _____	Office Stamp

Authorized Health Care Provider Signature: _____ Phone: _____

Name (printed): _____ Date: _____

(Must include Page 2 and appropriate signatures.)

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Parent/Guardian Request for the Administration of Medication: Prescription and Non-Prescription

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

This request is valid for a maximum of one year.

***** Please notify your child's school in writing if your child requires a separate allergen free lunch table.***

I agree with the above Allergy Action Plan: _____ Date: _____
Parent Signature

Emergency Contact Name/Numbers:

Parent/guardian: _____ Phone: _____

Cell: _____

School Nurse: _____ Phone: _____

Other Emergency Contacts:

Name/Relationship _____ Phone: _____

Name/Relationship _____ Phone: _____

Reviewed by
School Nurse _____ Date _____