

ALLERGY ACTION PLAN - Santa Cruz County Schools

Student
Photo

Student Name: _____ DOB: _____ Asthma: Y / N
List All Allergies: _____

PARENT -- PLEASE PROVIDE EPINEPHRINE AUTO-INJECTORS THAT WILL NOT EXPIRE DURING THE SCHOOL YEAR/

Padres, por favor proporcione la epinefrina auto-INYECTORES QUE NO EXPIRARÁN DURANTE EL AÑO ESCOLAR

I request that my child be allowed to take medication at school according to instructions from his physician. I understand it is my responsibility to bring the medication in the original pharmacy container labeled with student name, medication, dosage and directions (Ed Code 49423). I authorize school personnel to assist with this medication for my child as ordered by the physician. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480). I will notify the school of any changes in medication. I understand that the School Nurse may communicate with the Health Care Provider about this student when necessary. Pido que mi hijo sea permitido tomar medicamentos en la escuela conforme a las instrucciones de su médico. Yo entiendo que es mi responsabilidad de llevar el medicamento en la farmacia original recipiente rotulado con el nombre del alumno, la medicación, la dosis y las direcciones (Código de Educación 49423). Autorizo a personal de la escuela para ayudar con este medicamento a mi hijo/a según lo ordenado por el médico. Entiendo capacitados, el personal no médico puede ayudar con o administrar medicamentos (Código de Educación 49423 y 49480).

Parent/Guardian Signature / Firma de los Padres/Tutores

Fecha/Date

Phone/Telefono

PHYSICIAN -- COMPLETE THE MEDICATION LIST BELOW AND CHECK ALL THAT APPLY.

- ☐ **Epinephrine Auto-Injector** _____ **CIRCLE DOSE:** Epinephrine 0.15 mg Epinephrine 0.30 mg
☐ A SECOND DOSE OF EPINEPHRINE MAY BE GIVEN 10-15 MINUTES AFTER THE FIRST DOSE IF SYMPTOMS PERSIST OR RECUR
- ☐ ***Antihistamine:** _____ **Give by mouth DOSE:** _____
- ☐ ***Inhaler:** _____ **DOSE:** _____ **Puffs** **Every** _____ **Hours**

☐ **If this box is checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms**

SEVERE SYMPTOMS	ACTION
Any SEVERE SYMPTOMS after Suspected Ingestion/Exposure: ONE OR MORE OF THE FOLLOWING - LUNG: Difficulty Breathing, Audible Wheezing, Difficulty Talking - HEART: Pale, Blue, Faint, Dizzy, Confused, Weak Pulse - THROAT: Tight, Hoarse, Trouble Breathing / Swallowing - MOUTH: Significant Swelling of Tongue and Lips - SKIN: Many Hives over Body, Widespread Redness - G.I.: Repetitive Vomiting or Severe Diarrhea - OTHER: Feeling something bad is about to happen, anxiety, confusion OR a combination of mild or severe symptoms from different body areas	1. INJECT EPINEPHRINE IMMEDIATELY 2. CALL 911 3. BEGIN MONITORING (SEE BOX BELOW) 4. GIVE ADDITIONAL MEDICATIONS IF ORDERED ABOVE * *Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE
MILD SYMPTOMS ONLY	ACTION
Any MILD SYMPTOMS only: - MOUTH: Itchy Mouth - NOSE: Itchy, Runny Nose, Sneezing - SKIN: A Few Hives, Mild Itch - G.I.: Mild Nausea, Discomfort	1. GIVE ANTIHISTAMINE, IF ORDERED ABOVE 2. Stay With the Student. Alert Office and Parent/Emergency Contacts 3. IF SYMPTOMS BECOME SEVERE, SEE ABOVE, USE EPINEPHRINE AND CALL 911 4. Begin Monitoring (see box below)

MONITORING

- Stay with student
- Tell paramedic Epinephrine was given, **note time**. If a second dose is given, **note the time**.
- For a severe reaction: **KEEP STUDENT HORIZONTAL -- LEGS RAISED -- TURN ON SIDE IF NAUSEOUS**
- A second dose of Epinephrine may be given 10-15 minutes after the first dose if checked above.
- If breathing stops at any time during the procedure initiate CPR immediately.**

☐ **Student to carry medication and self-administer. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication. If the student is younger than 18, the parent/guardian assumes all liability related to this patient's use, timing, and technique in self-administering this medication.**

Physician Signature: _____

Date: _____

Student Contract for Carrying Own Medication: I will be responsible for carrying, administering, and keeping my medication safe at all times. I will use the medication in the way prescribed by my physician. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing. Signed:

Clinic Stamp