**ALLERGY ACTION PLAN**

 **Santa Cruz County Schools**

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_ Asthma: Y / N

List All Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  Photo

This authorization is valid for one calendar year.

**PARENT – PLEASE PROVIDE EPINEPHRINE AUTO-INJECTORS WHICH 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 instruction 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 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**



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| **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** | INJECT EPINEPHRINE IMMEDIATELY1. **CALL 911**
2. **BEGIN MONITORING (SEE BOX BELOW)**
3. **GIVE ADDITIONAL MEDICATIONS IF ORDERED ABOVE \* .**

\*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis).**USE EPINEPHRINE** |

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| **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 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

1. Stay with student
2. Tell paramedic Epinephrine was given, **note time**. If a second dose is given, **note time**.
3. For a severe reaction: **KEEP STUDENT HORIZONTAL -- LEGS RAISED -- TURN ON SIDE IF NAUSEOUS**
4. 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 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Clinic Stamp

**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: