ALLERGY TREATMENT PLAN AND THE PERMISSION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

STUDENT'S NAME:_____ DOB_____

ADDRESS:_____PHONE #_____

Does this child have Asthma? Yes___ No____

SPECIFIC ALLERGY:_____

INSTRUCTIONS: PLEASE MARK IN ORDER BELOW 1-2-3-4 (ect)

_____Observe student for signs of anaphylaxis x 2 hours

_____Administer **adrenaline** before symptoms occur. EpiPen Jr. Adult

_____Administer **adrenaline** if symptoms occur. EpiPen Jr. Adult

_____Administer Benadryl___tsp./mg

_____Administer_____

_____Call 911, transport to ER if symptoms occur for evaluation, treatment and observation.

1. Medication shall be administered from_____to_____
2. Relevant side effects to be observed: _____
3. Is student allowed to self-administer medication with Parent permission yes _____ no _____

Physician's Signature_____MD

Phone # _____

Parent Signature_____Date_____

May we contact the Physician regarding the above mentioned medications? YES____ NO____

Permission to share this information with teachers, YES _____ NO _____

SYMPTOMS OF ANAPHYLAXIS:
Chest tightness, cough, shortness of breath, wheezing
Tightness in throat, difficulty swallowing, hoarseness
Swelling of lips, tongue and throat
Itching mouth, itchy skin, hives or swelling
Stomach cramps, vomiting, diarrhea
Dizziness or faintness