Rocklin Unified School District

Health Services

www.RocklinUSD.org/Health

Allergy/Anaphylaxis Action Plan

Student Name	Birth Date	Grade
Address	Home Phone	Work Phone

Health Care Provider Authorization
For the Administration of Medication by School Personnel

Allergic Reaction to:_____

Symptoms	Give Checked Medication** ****To be determined by physician authorizing treatment**	
If a food allergen has been ingested, but no symptoms	□ Epinephrine	□ Antihistamine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine	□ Antihistamine
Skin – Hives, itchy rash, swelling of the face or extremities	□ Epinephrine	□ Antihistamine
Gut – Nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine	□ Antihistamine
Throat - Tightening of throat, hoarseness, hacking cough	□ Epinephrine	□ Antihistamine
Lung - Shortness of breath, repetitive coughing, wheezing	□ Epinephrine	□ Antihistamine
Heart - Weak or thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine	□ Antihistamine
Other_____	□ Epinephrine	□ Antihistamine
If reaction is progressing (several of the above areas affected), give	□ Epinephrine	□ Antihistamine

MEDICATIONS ORDERED

The above named student is approved to use the following medications in accordance with the directions on the packaging.

Student Age: _____ **Student Weight:** _____

EPINEPHRINE AUTO INJECTOR:

Dose: ☐ 33-66 pounds -Jr Strength 0.15mg
☐ >66 pounds – 0.3mg
☐ Other_____

Time: ☐ 1st dose as needed
☐ 2nd dose in ___ minutes if symptoms are not resolved
☐ Other: _____

Method of administration: ☐IM ☐_____

ANTIHISTAMINE:

Medication: _____

Dose: ☐ 12.5 mg ☐ 25mg ☐ 37.5mg ☐ 50 mg
☐ Other:_____ *Please note - if a range is ordered the lowest dosage will be given*

Time:
☐ as needed
☐ Other: _____

Method of administration: ☐Oral ☐_____

If epinephrine is given or you feel the student is in a life-threatening situation be sure to:

1. Call 911 at the beginning of the crisis
2. Administer the medication as ordered if possible
3. Ensure adequate airway
4. Perform CPR if needed
5. Call Nurse
6. Call Parent
7. Assist paramedics as needed

Authorized Consent for Management of Severe Anaphylaxis/Allergic Reaction at School

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the School Nurse. This authorization is for a maximum of one (1) year. If changes are indicated, I will provide new written authorization. (May be faxed)

- I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and administer the medication by him/her.
- It is my professional opinion that _____ should NOT carry or administer his/her medication by him/her.

Physician Signature _____ Date _____

Physician Printed Name_____ **Stamp:**

Address_____

Telephone (_____)_____-_____

Parent Consent and Authorization

I (we), the undersigned, the parent(s)/guardians of the above named student, request my (our) student be assisted with or administered the following medication in accordance with the California Education Code 49423.5 and Board Policy/Administrative Regulation. I agree to:

1. Provide all medications, supplies and equipment.
2. Notify the school if there is a change in the student's health status or attending physician.
3. Notify the school immediately and provide a new consent for any changes in the doctor's orders.
4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.

I authorize the school to communicate with the Authorized Health Care provider when necessary in regards to this specific medication and medical condition.

Parent/Guardian Signature_____ Date_____

Principal's Signature:_____ Date:_____

Nurse's Signature:_____ Date:_____