



EMERGENCY ALERT/ ALLERGY ACTION PLAN
AND
PARENT/ PHYSICIAN AUTHORIZATION FOR MEDICATION ADMINISTRATION

ALLERGY TO: \_\_\_\_\_

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Teacher \_\_\_\_\_

Asthmatic Yes\*\* [ ] No [ ] \*\*High risk for severe reaction

PLACE STUDENT PICTURE HERE

SIGNS OF AN ALLERGIC REACTION

Systems

Symptoms

- \*MOUTH Itching & swelling of the lips, tongue or mouth
\*THROAT Itching and/or a sense of tightness in the throat, hoarseness, and a hacking cough
\*SKIN Hives, itchy rash, and/or swelling about the face or extremities
\*GUT Nausea, abdominal cramps, vomiting, and/or diarrhea
\*LUNG Shortness of breath/ or difficulty breathing repetitive coughing, and/or wheezing
\*HEART "Thready" pulse, "passing-out"

The severity of symptoms can quickly change. \*All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

- 1. If the only symptom(s) are: \_\_\_\_\_
give: \_\_\_\_\_
Medication Dose Route

Then call:

- 2. Mother \_\_\_\_\_ Father \_\_\_\_\_, or emergency contacts.
3. Doctor \_\_\_\_\_ at \_\_\_\_\_

ACTION FOR MAJOR REACTION ( please check all that apply)

- 1. [ ] If ingestion is suspected and/or symptom(s) are: \_\_\_\_\_
2. [ ] If insect or bee sting and/or symptom(s) are: \_\_\_\_\_
3. [ ] If \_\_\_\_\_ and/or symptom(s) are \_\_\_\_\_

give: \_\_\_\_\_ IMMEDIATELY!!
Medication Dose Route

Then call:

3. 911 (ask for advance life support)

- 4. Mother \_\_\_\_\_ Father \_\_\_\_\_ or emergency contacts
4. Doctor \_\_\_\_\_ at \_\_\_\_\_

DO NOT HESITATE TO CALL 911!!!

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN:**

Name of Physician: \_\_\_\_\_ Office Phone Number: \_\_\_\_\_

This student has been diagnosed with \_\_\_\_\_  
(Type of Allergy)

What are the signs and symptoms of the above stated allergy? \_\_\_\_\_

Age of Diagnosis: \_\_\_\_\_

Medication(s)	Dosage	Route	Frequency
Epi Pen	_____	_____	_____
Epi Pen Jr.	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This plan of care and medication authorization is in accordance with the student's medical management.

**Current School Year**  (please check)

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date**

**PARENTAL CONSENT**

I give my permission for school personnel to administer prescribed medication listed above and provide emergency treatment to my child. I assume full responsibility for providing to the school the prescribed medication needed by my child. I agree to notify the school if a change in my child's condition occurs. I agree to allow the information on this health care plan to be shared with the adults responsible for my child's care. I have read, understood, and do now support the Health Care Plan outlined above. I hereby release the Lynchburg City School Board, its employees, and agents from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I am aware that should I move to another attendant zone within Lynchburg City, I will need to work with the new school to continue with the above health care plan for my child.

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of School Nurse / Health Assistant**

\_\_\_\_\_  
**Date**

A new Health Care Plan and Authorization for Medication Administration Form is required on an annual basis and a revision made when there is a significant change in the student's health status.