MADISON CITY SCHOOLS SCHOOL YEAR: ________________________

SEVERE ALLERGY EMERGENCY PLAN

Section 1: Parent (Please Print)

Severe Allergy To: ______________________________________ Student also has Asthma? [] Yes [] No

Section 1: Parent (Please Print):

Student Name:		DOB:	Weight:
Medications Taken At Home:			
Transportation To and From School:		AM:	PM:
Parent Contact	Name	Cell Phone	Work Phone
Emergency Contact	Name	Cell Phone	Work Phone
Physician:		Phone Number:	
Preferred Hospital in Case of Emergency:			

Section II: Physician (Please Print)

IF YOU SEE THIS….	DO THIS…
Contact with or ingestion of allergen with no symptoms	1. Administer medication? [] Yes [] No (If '**yes**':Requires a School Medication Prescriber/ Parent Authorization) Medication:_____________________________________ Medication dosage:________________________________ 2. Remain with the student. 3. Call parent or emergency contact 4. Observe student for ____minutes before return to class 5. Recheck student in 1 hour.
Symptoms of mild or early allergic reaction: • Itching • Hives • **No** Respiratory Distress	1. Administer medication? [] Yes [] No (If '**yes**' Requires a School Medication Prescriber/ Parent Authorization) Medication:_____________________________________ Medication dosage:________________________________ 2. Other: ______________________________________
Symptoms of **severe** allergic reaction: • Mouth Tingling, Swelling of Face/Lips/ Tongue/Throat • Respiratory Distress: cough, wheeze, stridor • Weak pulse, low blood pressure, pallor • Abdominal cramping, nausea, vomiting, diarrhea	Administer Epinephrine? [] Yes [] No (If '**yes**': Requires a School Medication Prescriber/ Parent Authorization) [] Epi-pen: [] 0.3 mg [] 0.15 mg [] Auvi-Q [] 0.3 mg [] 0.15 mg [] Twinject [] 0.3 mg [] 0.15 mg **Follow instructions for administration as illustrated on box** **1. Call 9-1-1** **2.** Call parent/emergency contact **3.** Remain with student until EMS personnel arrive **4.** Give used auto injector, to EMS personnel, if administered May repeat above Epinephrine dose if no improvement in signs/symptoms after 15 minutes? [] Yes [] No
BUS PLAN: Pull Over, Call 911, Notify School	

All medications given at school require a School Medication Prescriber/Parent Authorization (PPA) signed by the prescriber.

If student "self-carries" and "self-administers" medication, will a "back- up" dose be kept with the school nurse? [] Yes [] No

For FIELD TRIPS: the auto injector should NOT be left in a backpack on the bus or with a teacher who is not with the student.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.

I give permission for the release of my child's medical information, in the event of an emergency.

______________________________ ______________________________ ______________________________

Physician Signature Date Parent Signature Date School Nurse Signature Date

______________________________ ______________________________ ______________________________

Teacher Signature Date Sponsor/Coach Signature Date

FOR SCHOOL NURSE USE ONLY

Medication	Self- Carry?	Self- Administer?	Expiration Date	Location of Medication