FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

School Year:_____
School Site:_____

SEVERE ALLERGY ACTION PLAN

Name: _____ D.O.B.: _____ Grade: _____

Mildly allergic to:_____ Symptoms : _____	**Severely allergic to:**_____ Symptoms : _____
Asthma: ❑ Yes (Please complete an Asthma Action Plan) ❑ No	

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

FOR MILD SYMPTOMS SYSTEMS:
NOSE: Itchy or runny nose, sneezing
MOUTH:Itchy mouth
SKIN: A few hives, mild itch
GUT : Nausea or discomfort

DO THE FOLLOWING:

1. Give antihistamine, if prescribed
2. Give inhaler (bronchodilator) for wheezing, if prescribed
3. Notify emergency contact
4. Monitor symptoms for 15 minutes

MEDICATIONS/DOSES:

Antihistamine: Name: _____

Dose:_____mg, orally

Inhaler: Name: _____

Dose: _____ puffs, inhaled

For MILD symptoms that appear to be progressing to SEVERE symptoms. GIVE EPINEPHRINE and Call 911.

_____ **If antihistamine was administered before epinephrine, do not give additional dose of antihistamine.**
Dr. Initials

Additional Comments:

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS:
LUNG: Shortness of breath, wheezing, repetitive cough
HEART: Pale or bluish skin, faintness, weak pulse
THROAT: Tight or hoarse throat, trouble breathing or swallowing
MOUTH: Significant swelling of the tongue or lips
SKIN: Many hives over the body, widespread redness, dizziness
GUT: Repetitive vomiting, severe diarrhea
OTHER: Feeling of "doom," anxiety, confusion, altered level of consciousness
OR A COMBINATION OF SYMPTOMS from more than one body system.

DO THE FOLLOWING:
1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
• Consider giving additional medications following epinephrine:
  ❖ Antihistamine (if prescribed)
  ❖ Inhaler (bronchodilator) if wheezing (if prescribed)
• Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
• If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
• Alert emergency contacts.
• Transport student to ER, even if symptoms resolve. Student should remain in the ER for at least 4 hours because symptoms may return.

MEDICATIONS/DOSES for Severe Allergy Reaction:

Self Carry/Self Administer ❑ Yes ❑ No, for the following medications

Epinephrine Dose: ❑ 0.15 mg IM ❑ 0.3 mg IM

Antihistamine: Name: _____ Dose:_____mg, orally

Inhaler: Name: _____ Dose: _____ puffs, inhaled

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician Signature** **Date**

School Year:_____
School Site:_____

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ Date of Birth: _____ Grade : _____

School Year: _____ /_____ School Site: _____

California Education Code Section 49423 allows the school nurse or other trained, non-medical school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication, supplies, and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and the medication must be supplied in the **original package or original prescription bottle with the pharmacy label attached** (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered, and all medication containers must include a label with the student's name, physician's name, name of the medication, and the directions for use.

Initial below:

_____ I authorize and hereby request that designated school personnel assist my child in taking the prescribed medication(s) (including prescribed over-the-counter medication, nutritional supplements, and herbal remedies) as prescribed by my child's health care provider.

_____ I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement.

_____ I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this/these medication(s).

_____ I have read and understood the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I also understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization at the beginning of each school year, or if any changes in prescription occur.

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

_____	_____	_____
Cell Telephone	Work Phone	Home phone