WCSCC
WAYNE COUNTY SCHOOLS **CAREER CENTER**
Education at its Finest

Place child's picture here

******THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR and START FROM THE TIME IT'S SIGNED BY THE PHYSICIAN AND PARENT/GUARDIAN******

Anaphylactic/Allergy Action Plan

School Year: _____ Grade/Class: _____

Student's Name: _____ Date of birth: _____

Address: _____ City: _____ Zip: _____

Asthmatic: YES* NO ***High risk for severe reaction**

Physician Name (Printed): _____ Physician Phone: _____

ALLERGY:

☐Latex
☐Peanuts
☐Tree Nuts (Walnuts, Pecans, Cashews, Almonds, Pistachios, Macadamia Nuts etc.)
☐Stinging Insects (list): _____
☐Medications (list): _____
☐Other: _____

Age of student when allergy first discovered: _____
How many times has your student had a reaction (Please circle one below)?
Never Once More than once, explain: _____
_____
Explain past reactions and symptoms: _____
_____
Do the reactions seem to be the (circle one) Same Better Worse

Signs of an allergic reaction: The severity of symptoms can quickly change. All the symptoms listed below can potentially progress to a life-threatening situation. Anaphylaxis is any severe symptoms, such as trouble breathing, repeated vomiting, passing out, or throat tightness **OR** two or more mild symptoms, such as hives and vomiting or coughing and belly pain

SYSTEMS:	**SYMPTOMS:**
MOUTH	ITCHING & SWELLING OF THE LIPS, TONGUE, OR MOUTH
THROAT	ITCHING AND/OR SENSE OF TIGHTNESS IN THE THROAT, HOARSENESS OR 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, REPETITIVE COUGHING AND/OR WHEEZING
HEART	THREADY PULSE, PASSING OUT

Anaphylactic/Allergy Action Plan Continued: Student Name: _____

ACTION FOR MAJOR REACTION

If symptom(s) are: _____**Give**

Medication: _____ Strength: _____ Dose: _____

Call: 9-1-1-Activate EMS and call Parent/Guardian

Instructions/Precautions/Possible side effects_____

A second EPIPEN may be given within 5 minutes if the 1st dose doesn't work **YES** **NO**

ACTION FOR MINOR REACTION

If only symptom(s) are: _____

_____**Give**

Medication: _____ Strength: _____ Dose: _____

Then call: Parent/Guardian/Emergency Contact listed below

1. Parent/Guardian: _____Phone: _____
2. Emergency Contact: _____Phone: _____
3. Emergency Contact: _____Phone: _____

AGREEMENT: PARENTS ARE RESPONSIBLE FOR PROVIDING ALL NECESSARY MEDICATION INCLUDING EPIPENS AND ANTIHISTAMINES TO THE CLINIC IN A TIMELY MANNER.

- I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication must be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist.
- I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber.
- I release and agree to hold the Board of Education, it's officials, and it's employees harmless from all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Healthcare Provider: Please initial here _____IF STUDENT has been instructed on how to use Injectable Epinephrine and is able to self-administer; thus, **enabling the student to carry an Injectable Epinephrine in any form on his/her person while at school. If the student can self-carry it is required by law for an additional Epinephrine Auto Injector to be kept in the school clinic.**

PARENT/GUARDIAN AND STUDENT: Please initial here _____/_____ to indicate you have been instructed and if student self-administers Injectable Epinephrine during school, he/ she will notify an adult school staff member to activate EMS. By initialing, you are acknowledging that **by law, an additional EPIPEN/AUVI-Q must be brought into the school and kept in the clinic (ORC 3313:718)**

Signatures: Represent agreement with the above Information/Action Plan

PARENT/LEGAL GUARDIAN: _____ Date: _____

HEALTHCARE PROVIDER SIGNATURE: _____Date: _____

SCHOOLNURSE: _____ Date: _____