Physician Order/Severe Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ **D.O.B:**_____ **Grade:**_____

ALLERGIC TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT (This section to be completed by authorizing physician)

Symptoms:		Give Checked Medications	
• If exposure to allergen (e.g., sting, food ingested), but has no symptoms		☐ EpiPen	☐ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
• Throat ❖	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
• Lung ❖	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
• Heart ❖	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
• Other ❖	_____	☐ EpiPen	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

The severity of symptoms can quickly change. ❖ Potentially life-threatening. When both EpiPen and Antihistamine are checked, **EpiPen will be given first**. Antihistimine or other med given only if student alert and able to swallow.

DOSAGE

Epinephrine: Inject intramuscularly (**check one**) ☐ EpiPen ☐ EpiPen Jr. (See reverse side for instructions)

Antihistamine: give _____ **Other**: give _____
Medication/dose/route Medication/dose/route

Physician's Signature_____ Date*_____
(Required)

Physician's name (printed) _____ Phone _____ Fax number _____

☐ **This student is both capable and responsible to self-administer the EpiPen. This student may carry his/her EpiPen:**

_____ _____ _____
Physician's Signature and Date Parent Signature and Date Student's Signature and Date

• STEP 2: EMERGENCY CALLS (To be completed by parent/guardian) •

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call **Parent/Guardian** or Emergency contact(s):

Name/Relationship	Phone Number(s)	
a._____	1._____	2._____
b._____	1._____	2._____
c._____	1._____	2._____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel, including unlicensed persons, to give the medication described above as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools, Arlington Department of Human Services, Arlington County, and any of its officers, staff members, or agents from any lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student by administration of this medication to him/her as requested by the parents, including any adverse effects to the medication.

Parent/Guardian Signature_____ **Date**_____

*Order form good for one school year and Summer School. (good for 12 months)

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

_____ _____ _____
SHA Signature and Date Name of PHN Contacted by Phone & Date PHN Signature and Date

Please note: This form replaces the *Health Alert, Severe Allergy* form and the use of *Authorization for Medication* for severe allergy medication orders only.

Revised 11.05