TRADERS POINT CHRISTIAN SCHOOLS

TRAINING SCHOLARS. MAKING DISCIPLES. GRADUATING LEADERS.

Allergy Medical Action Plan

Student Name: ____ DOB: ________________

Teacher/Grade: ____________________________________

Allergy(s)and type of reaction/severity: ____
____
____

Asthma diagnosis: ☐ YES ☐ NO Sit at allergy-friendly table ☐ Sit with class ☐

STEP 1: Treatment

Symptoms	Give Checked Medication* *To be determined by physician authorizing treatment
If allergen has been ingested, but no symptoms	☐ Antihistamine ☐ Epinephrine
Mouth: itching, tingling, or swelling of lips, tongue, mouth	☐ Antihistamine ☐ Epinephrine
Skin: hives, itchy rash, swelling of the face or extremities	☐ Antihistamine ☐ Epinephrine
Gut: nausea, abdominal cramps, vomiting, diarrhea	☐ Antihistamine ☐ Epinephrine
Throat: tightening of throat, hoarseness, hacking cough	☐ Antihistamine ☐ Epinephrine
Lungs: shortness of breath, repetitive coughing, wheezing	☐ Antihistamine ☐ Epinephrine
Heart: thready pulse, low blood pressure, fainting, pale, blueness	☐ Antihistamine ☐ Epinephrine
Other:	☐ Antihistamine ☐ Epinephrine
If reaction is progressing (several of the above areas affected)	☐ Antihistamine ☐ Epinephrine

THE SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY AND BECOME POTENTIALLY LIFE-THREATENING

Medication and Dosage:

Antihistamine:____
(name, dose, frequency and route)

Ephinephrine:____
(name, dose, frequency and route)

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

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1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be required.

2. Emergency Contacts:

	Name/Relationship:	Number:
a.	______________________________	_________________________
b.	______________________________	_________________________

Even if a parent/guardian cannot be reached, do NOT hesitate to medicate or take child to a medical facility.

If it is deemed appropriate for this student to self-carry medication, an Authorization for Students to Carry Prescription/OTC Medication form will need to be filled out and signed by the physician, student and parent/guardian.

PERMISSION TO GIVE MEDICATION

Permission is hereby granted to the school nurse or his/her designee to supervise my child in taking the following prescribed/OTC medication(s).

I hereby release and discharge Traders Point Christian Schools and its employees from any and all liability in case of an accident or any other mishap in supervising said medication due to any side effects, illness or other injury which might occur to my child through supervising said medication.

I understand that:

- All medications must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia.
- Medications (prescribed and OTC) MUST be in the original container/packaging and include the original prescription label from the pharmacy with student's name, DOB, medication name, dosage, route and frequency.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data related to the medication(s).
- New medications will not be given unless a new form is completed.
- All medications (including OTC) will be taken directly to the front office or school nurse office by the parent or guardian. Students may NOT have medications in their possession, except with a physician's request on file.
- A daily record shall be kept on each medication administered at school.
- At the end of the school year, any and all medications must be picked up by a parent/guardian. Any medication not picked up from the school by the end of the last school day or the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and another school employee.

Parent/Guardian Signature:______________________________________ Date:__________________

Healthcare Provider Name:______________________________________

Healthcare Provider Signature:___________________________________ Date:__________________

Reviewed by School Nurse:______________________________________ Date:__________________