Allergy Treatment Plan
Frederic School District

STUDENT: _____ Birthdate: _____ School: _____ Grade/Class: _____

Physician: _____

Allergic to : _____

if exposed by being stung, ingesting, inhaling, skin contact
(Circle above as indicated) Wash w soap & water if exposed

Epinephrine medication: (Circle appropriate) Give by injection
EpiPen EpiPen Junior Auvi-Q 0.3 mg Auvi-Q 0.15 mg

Antihistamine: Benadryl / Diphenhydramine _____mg, Other _____
Give orally

Treat as indicated below

If exposed, but no symptoms		Antihistamine	Epinephrine/call 911 _____
Mouth	Itching, tingling	Antihistamine	Epinephrine/call 911
Skin	Hives, itchy rash, swelling (except as below)	Antihistamine	Epinephrine/call 911
Swelling	Swelling of lips, tongue, mouth or face	Antihistamine	Epinephrine/call 911
Gut	Nausea, abdominal cramps, vomiting, diarrhea	Antihistamine	Epinephrine/call 911
Throat **	Tightness of throat, hoarseness, hacking cough	Antihistamine	Epinephrine/call 911
Lung **	Shortness of breath, repetitive coughing, wheezing	Antihistamine	Epinephrine/call 911 _____
Heart **	Fainting, pale, blue, weak or thready pulse, low BP	Antihistamine	Epinephrine/call 911 _____
Other ** _____		Antihistamine	Epinephrine/call 911 _____

** Potentially Life-threatening. Severity of symptoms can change quickly. CALL 9-1-1!

Any additional directions: _____

PARENT/GUARDIAN CONSENT:

- I request and authorize that this medication/ procedure be administered at school by non-medically trained school personnel.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication/procedure at school.
- I agree that a parent/guardian/responsible adult will deliver the medication to the school office in its original, properly labeled container. (Request extra bottle from pharmacist.)
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication/ procedure or the conditions for which it is prescribed.
- AUTO-INJECTING EPINEPHRINE: This student is capable of self-administration and may carry EpiPen or Auvi-Q and self-administer in school. Yes _____ No _____
- HIGH SCHOOL STUDENTS ONLY: This student is capable of self-administration and may carry and self-administer the above over-the-counter antihistamine in school. Yes _____ No _____
- My signature indicates that I have fully read and understand the above information.

_____ _____ _____
Signature of Parent/Legal Guardian | Telephone Home | Business / Cell | Date

PHYSICIAN ORDER:

AUTI-INJECTING EPINEPHRINE: This student and parents/guardians have been instructed in self-administration and student may carry and self-administer in school. Yes _____ No _____

The above medication/procedure is to be administered/ performed in accordance with the above instructions and agreements. I agree to exchange information verbally or in writing with school personnel regarding this medication/ procedure or the conditions for which it is prescribed and understand medication will be given by non-medically trained school personnel. Please contact me if the following symptoms occur: _____

_____ _____ _____ _____
Physician's Signature | Date | Print Physician's Name and Address | Phone number