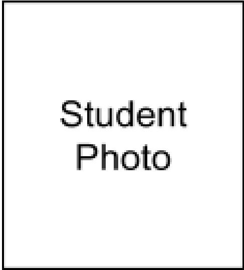
Anchorage School District

Allergy/Anaphylaxis Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID



MEDICAL PROVIDER AUTHORIZATION

BACKGROUND

Allergy/Anaphylaxis Trigger(s)

Does this student have asthma? **Having asthma increases the risk of having a more severe allergic reaction.* ☐ YES ☐ NO

STUDENT SYMPTOMS

Mild Symptoms

☐ Itchy Nose ☐ Itchy Mouth ☐ Sneezing ☐ A few hives ☐ Other ______________________________

Severe Symptoms

☐ SOB, wheezing, or coughing ☐ Cyanotic ☐ Weak pulse ☐ Faint or dizzy ☐ Tight or hoarse throat
☐ Vomiting or diarrhea, if severe ☐ Trouble swallowing ☐ Multiple hives ☐ Feeling of doom
☐ Pain or tightness in chest ☐ Unconsciousness ☐ Abdominal cramping or pain
☐ Swollen face, eyes, or tongue ☐ Altered mental status ☐ Other ______________________________

MEDICATION ORDER

Is this student able to safely carry an Epinephrine auto-injector during school hours? ☐ YES ☐ NO
(If this student is not able to self-treat, a nurse or trained adult may administer Epinephrine auto injector)

☐ Any available PO antihistamine per package instructions for *Mild Symptoms as indicated above.*

☐ Epinephrine 0.15 mg IM for *Severe Symptoms as indicated above.*

☐ Epinephrine 0.3 mg IM for *Severe Symptoms as indicated above.*

☐ Other ____

ADDITIONAL COMMENTS

MEDICAL PROVIDER NAME/TITLE	*PHONE NUMBER*	*EMAIL*
MEDICAL PROVIDER SIGNATURE		*DATE*

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

Anchorage School District

Allergy/Anaphylaxis Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the medication(s) selected and allergy/anaphylaxis protocols listed on this plan be provided to my child. ***I will provide needed medications or supplies for care in school. Prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.*** I understand that, in the absence of the nurse, other trained Anchorage School District ("ASD") personnel may administer this medication.

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	***RELATIONSHIP TO STUDENT***	***PHONE NUMBER***
PARENT/GUARDIAN SIGNATURE		***DATE***

STUDENT SELF-CARRY AGREEMENT

I have been trained in the use of my Epinephrine auto-injector and allergy medication. I understand the signs and symptoms of an allergic reaction and agree to have my Epinephrine auto-injector available at all times. I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) IMMEDIATELY if I use my Epinephrine auto-injector. I will not share my medication with other students or leave my medication unattended. I will use my allergy medication only for the prescribed purpose.

STUDENT NAME	
STUDENT SIGNATURE	***DATE***

NURSE PLAN REVIEW AND STAFF TRAINING

I have reviewed the Allergy/Anaphylaxis Care Plan for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	***DATE***