Anchorage School District

ALLERGY ACTION PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

ALLERGIES: _____

_____

Which of these allergies cause an anaphylactic reaction? _____

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

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

WHAT DOES THIS STUDENT'S ALLERGIC REACTION LOOK LIKE?

Minor Allergic Reaction Symptoms

☐ Hives ☐ Scratchy throat ☐ Itching ☐ Rash ☐ Nasal Congestion ☐ Watery or itchy eyes

Severe Allergic Reaction Symptoms

☐ Abdominal pain or cramping ☐ Pain or tightness in the chest ☐ Diarrhea ☐ Wheezing or coughing

☐ Swelling of the eyes, face, or tongue ☐ Heart palpitations or racing ☐ Dizziness ☐ Nausea or vomiting

☐ Difficulty swallowing or talking ☐ Sense of pending doom ☐ Unconsciousness ☐ Shortness of breath

MEDICAL PROVIDER AUTHORIZATION

MINOR ALLERGIC REACTION SYMPTOMS	SEVERE ALLERGIC REACTION SYMPTOMS	
• Hives (itchy red spots on the skin) • Scratchy throat • Itching • Rash • Nasal congestion (known as rhinitis) • Watery or itchy eyes	• Abdominal cramping or pain • Pain or tightness in the chest • Diarrhea • Wheezing or coughing • Swelling of the face, eyes, or tongue • Heart palpitations or racing • Dizziness (vertigo) / lightheadedness	• Nausea or vomiting • Difficulty swallowing or talking • Sense of pending doom • Unconsciousness • Shortness of breath • Flushing of the face

MEDICATION	DOSE	ROUTE	NOTES
☐ Any available antihistamine	Per package	Oral	For minor allergic reaction
☐ EpiPen Jr. auto-injector	0.15 mg	IM Injection	For severe allergic reaction
☐ EpiPen auto-injector	0.3 mg	IM Injection	For severe allergic reaction
☐			

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

Anchorage School District
ALLERGY ACTION PLAN

PARENT / GUARDIAN AUTHORIZATION

I request that the medications selected on this plan be given to my child. I understand that, in the absence of the school nurse, other trained school personnel may administer this medication. I agree to defend and hold school district employees harmless from any liability for the results of the medication, or the manner in which it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and the school district as part of the provision of my child's care. I understand that this medication will be destroyed at the end of the school year, per DEA federal requirements, unless I pick up the remaining medication by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

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.

STUDENT SELF-CARRY AGREEMENT

I have been trained in the use of my EpiPen auto-injector and allergy medication. I understand the signs and symptoms of an allergic reaction and agree to have my epi-pen auto-injector available at all times. I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) IMMEDIATELY if I use my EpiPen 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 (PRINTED)	
STUDENT SIGNATURE	DATE

NURSE PLAN REVIEW AND STAFF TRAINING

I have reviewed the *Allergy Action 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 (PRINTED)	
NURSE SIGNATURE	DATE