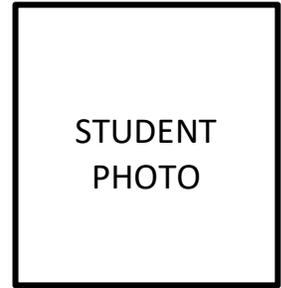




## Anchorage School District ALLERGY ACTION PLAN



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

**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
<ul style="list-style-type: none"> <li>Hives (itchy red spots on the skin)</li> <li>Scratchy throat</li> <li>Itching</li> <li>Rash</li> <li>Nasal congestion (known as rhinitis)</li> <li>Watery or itchy eyes</li> </ul>	<ul style="list-style-type: none"> <li>Abdominal cramping or pain</li> <li>Pain or tightness in the chest</li> <li>Diarrhea</li> <li>Wheezing or coughing</li> <li>Swelling of the face, eyes, or tongue</li> <li>Heart palpitations or racing</li> <li>Dizziness (vertigo) / lightheadedness</li> </ul> <ul style="list-style-type: none"> <li>Nausea or vomiting</li> <li>Difficulty swallowing or talking</li> <li>Sense of pending doom</li> <li>Unconsciousness</li> <li>Shortness of breath</li> <li>Flushing of the face</li> </ul>

MEDICATION	DOSE	ROUTE	NOTES
<input type="checkbox"/> Any available antihistamine	Per package	Oral	For minor allergic reaction
<input type="checkbox"/> EpiPen Jr. auto-injector	0.15 mg	IM Injection	For severe allergic reaction
<input type="checkbox"/> EpiPen auto-injector	0.3 mg	IM Injection	For severe allergic reaction
<input type="checkbox"/>			

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