Port Edwards Public Schools
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Allergy Treatment & Emergency Plan

TO BE COMPLETED BY THE PARENT/GUARDIAN:

STUDENT:_____ **Grade/Class**:_____ **DOB**: _____

Current Weight: _____ **Allergy**: _____ **Asthmatic**: ☐ Yes ☐ No

Epinephrine: ☐ EpiPen ☐ Epipen Junior **Antihistamin:** ☐ Benadryl_____mg ☐ Other_____

This student may self-carry and self-administer EpiPen: ☐ Yes ☐ No

- I authorize that this medication be administered at school, potentially by non-medically trained personnel.
- I will supply medication in its original, updated, properly labeled container.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize the school to exchange information with my child's provider re: this medication/condition for which it's prescribed.
- I understand the parent/guardian/responsible adult should deliver all medication to the school.
- I understand that this consent is in effect for the current school year (may include summer school).
- I consent that this treatment be provided during school hours, at after hours school sponsored events & on field trips.
- I consent to the release of the information contained in this Allergy Plan to staff members who may need to know this information to maintain my child's health and safety.
- 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 at school.
- My signature indicates that I have fully read and understand the above information.

AT THE END OF THE SCHOOL YEAR, PLEASE (check one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my student

Name of Provider: _____ **Provider Phone Number:** _____

Signature of Parent/Guardian: _____ **Date:** _____

TO BE COMPLETED BY THE PROVIDER: *The above medication is to be administered/performed during the school day in accordance with the above instructions. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel.*

Student & parent/guardian have been instructed/student may self-carry & self-administer in school ☐ Yes ☐ No

Physician Name: _____ Phone #: _____

Physician Signature: _____ Date: _____

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Symptoms of Mild Allergic Reaction -> Give Antihistamine and Monitor

- Itching/Sneezing
- Hives
- Nausea/vomiting/diarrhea

Symptoms of Severe Allergic Reaction/Anaphylaxis -> Give Epinephrine

- **Shortness of breath, persistent cough, wheezing**
- **Pale/blue skin**
- **Weak pulse**
- **Feeling dizzy or lightheaded**
- **Trouble swallowing, sore or tight throat**
- **Swelling of lips or tongue**
- **Altered level of Consciousness**
- **Multiple Symptoms listed above for Mild Allergic Reaction**

Anaphylaxis First Aid:

- **Give epinephrine right away - note time**
- **Call 911**
- **Stay child child and have them lie down**
- **Call parent/guardian**
- **If symptoms do not improve with in 5 minutes, give second dose of epinephrine**
- **Place student on their side if the begin to vomit**

Reviewed 5/2023