DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

ALLERGIC REACTION/ ANAPHYLAXIS ACTION PLAN & CONSENT FORM

Last Name_____ First Name _____ DOB_____

School_____ Grade_____ School Year_____

TO BE COMPLETED BY PHYSICIAN

ALLERGIC TO_____ WEIGHT_____

PRESCRIBED MEDICATIONS

****Please give exact dose, ranges not accepted****

EPINEPHRINE BRAND_____ [ ] GENERIC OK

EPINEPHRINE DOSE [ ] 0.15mg IM [ ] 0.3mg IM [ ] GIVE REPEAT DOSE IN _____ MINUTES IF NEEDED

ANTIHISTAMINE BRAND_____ [ ] GENERIC OK

ANTIHISTAMINE DOSE_____ REPEAT DOSE EVERY _____HOURS

INHALER BRAND_____ [ ] USE WITH SPACER [ ] GENERIC OK

INHALER DOSE_____ REPEAT DOSE EVERY _____HOURS

PLEASE CHECK APPROPRIATE BOX(S) BELOW

[ ] GIVE EPINEPHRINE IMMEDIATLEY FOR *KNOWN* ALLERGEN EXPOSURE EVEN IF THERE ARE NO SYMPTOMS
[ ] GIVE EPINEPHRINE IMMEDIATELY FOR *LIKELY* ALLERGEN EXPOSURE FOR ANY SYMPTOMS

FOR ***SEVERE*** ALLERGIC REACTION SYMPTOMS INCLUDING: Shortness of breath, wheezing, repetitive cough, pale, blue, faint, weak pulse, dizzy, tight throat, hoarse, trouble breathing/ swallowing, significant swelling of the tongue and or lips, many hives over body, widespread redness, repetitive vomiting or severe diarrhea or a combination of mild or severe symptoms, give:

[ ] EPINEPHRINE [ ] ANTIHISTAMINE [ ] INHALER

FOR ***MILD*** ALLERGIC REACTION SYMPTOMS: Itchy/runny nose, sneezing, itchy mouth, a few hives, mild itch, mild nausea/ discomfort, give:

[ ] ANTIHISTAMINE [ ] INHALER

STAMP

PHYSICIAN SIGNATURE:_____

DATE:_____

ALLERGIC REACTION/ ANAPHYLAXIS ACTION PLAN & CONSENT FORM

LAST NAME_____ FIRST NAME_____

TO BE COMPLETED BY PARENT/GUARDIAN

EMERGENCY INFORMATION AND PARENT/GUARDIAN AUTHORIZATION

HOSPITAL_____ [ ] TAKE TO NEAREST HOSPITAL

PHYSICIAN NAME_____ PHONE_____

EMERGENCY CONTACTS

1.) NAME_____RELATION_____

HOME#_____CELL#_____ WORK#_____

2.) NAME_____ RELATION_____

HOME#_____CELL#_____ WORK#_____

3.) NAME_____RELATION_____

HOME#_____CELL#_____ WORK#_____

- I authorize school personnel to assist with the above medications for my child according to physician instruction. I understand that trained, non-medical personnel may assist with this medication (Ed Code Sec 49423 and 49480)
- I understand this form must be renewed whenever the prescription changes and at the beginning of each school year.
- I understand that it is my responsibility to bring medication to Health Office in pharmacy labeled container and that medications must not be expired. All medications and supplies must have student's name clearly marked.
- I request that my child have above prescribed medications on field trips or in case of disaster, according to physician instruction.
- I understand that 911 will be called in the event of a severe allergic reaction.
- I understand that by signing below I agree to release from liability the district, its officers, employees and agents for any loss, damage, injury or liability of any kind to any person caused or arising from the acts, omissions or negligence of the district, its officers, employees and agents related to the assistance of medication to my child.
- I give consent for the District Nurse/School Personnel to communicate with authorized healthcare provider for clarification purposes.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____