DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

ALLERGIC REACTION / ANAPHYLAXIS ACTION PLAN & CONSENT

Last Name _____First Name_____ DOB _____

School _____ Grade_____ School Year _____

↓↓↓ THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY ↓↓↓

ALLERGIC TO_____WEIGHT_____

****** THIS FORM IS NOT INTENDED FOR SEASONAL ALLERGIES******

→DIRECTIONS FOR **MILD** ALLERGIC REACTION SYMPTOMS INCLUDING:
A few hives on body, mild itch mouth or body, itchy/runny nose, sneezing, mild nausea/discomfort.
GIVE: [ ] ANTIHISTAMINE [ ] INHALER

→DIRECTIONS FOR **SEVERE** ALLERGIC REACTION SYMPTOMS INCLUDING:
Shortness of breath, wheezing, repetitive cough, pale, blue, faint, weak pulse, dizzy, tight throat, hoarse, trouble swallowing, significant swelling of tongue and/or lips, many hives over body, widespread redness, repetitive vomiting or severe diarrhea. Or a combination of two or more mild symptoms.
GIVE: [ ] EPINEPHRINE then call 911 [ ] ANTIHISTAMINE [ ] INHALER

[ ] GIVE EPINEPHRINE FOR ***KNOWN*** ALLERGEN EXPOSURE EVEN IF THERE ARE **NO SYMPTOMS**

[ ] GIVE EPINEPHRINE FOR ***LIKELY*** ALLERGEN EXPOSURE FOR **ANY SYMPTOMS MILD OR SEVERE**

EPINEPHRINE BRAND_____ [ ] GENERIC OK

DOSE: **[ ]0.15 MG IM -or- [ ]0.3 MG IM** [ ] GIVE REPEAT DOSE IN _____ MINUTES IF NEEDED

ANTIHISTAMINE BRAND_____ [ ] GENERIC OK

(NO RANGE) EXACT DOSE: _____**mg.** BY MOUTH, REPEAT EVERY _____ HOURS AS NEEDED

INHALER BRAND_____ [ ] USE WITH SPACER [ ] GENERIC OK

INHALER DOSE: _____ PUFFS REPEAT EVERY_____HOURS AS NEEDED

STAMP

MD SIGNATURE_____

DATE_____

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Last Name_____ First Name_____

↓↓↓ **TO BE COMPLETED BY PARENT/GUARDIAN** ↓↓↓

HOSPITAL_____ [ ] TAKE TO NEAREST HOSPITAL

PEDIATRICIAN_____ PHONE_____

EMERGENCY CONTACTS

1.) NAME_____ RELATION_____

PRIMARY PHONE# _____ SECONDARY PHONE#_____

2.) NAME_____ RELATION_____

PRIMARY PHONE# _____ SECONDARY PHONE#_____

☐ **My Child MUST eat snacks/meals at the school designated food allergy table.**

☐ **My Child may eat snacks/meals at any table.**

☐ **If my child's healthcare provider has indicated a repeat dose for epi-pen,**

I have provided 2 epi-pens to the school.

PARENT/GUARDIAN AUTHORIZATION

- I authorize school personnel, including trained non-medical personnel (Ed. Code Sec 49423 and 49480) to assist my child with the above medication according to physician instruction.
- I give permission to school personnel to contact my child's physician for any clarification purposes.
- I am aware that this form must be renewed whenever the prescription changes and every school year.
- I understand that medication must not be expired and that prescription medications must be in original pharmacy labeled packaging. I will mark all "over the counter" medications/supplies with my child's name.
- I request that my child have above prescribed medications available on all field trips or in case of disaster.
- I understand pick-up and delivery of all medications must be done by parent/guardian and I am aware that medications not picked up on the last day of school before summer break will be discarded.
- 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, it's officers, employees and agents related to the assistance of medication to my child.

Parent/Guardian Signature_____DATE_____