Physician Order/Severe Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ **D.O.B:**_____ **Grade:**_____

ALLERGIC TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT (This section to be completed by authorizing physician)

Symptoms: **Give Checked Medications**

- If exposure to allergen (e.g., sting, food ingested), but has no symptoms ☐ Epinephrine ☐ Antihistamine

MILD SYMPTOMS

• Mouth	Itchy runny nose, sneezing	☐ Epinephrine ☐ Antihistamine
• Skin	A few hives, mild itch	☐ Epinephrine ☐ Antihistamine
• Gut	Mild nausea/discomfort	☐ Epinephrine ☐ Antihistamine

SEVERE SYMPTOMS - Potentially Life-Threatening

• Throat	Tightening of throat, hoarseness, hacking cough
• Lung	Shortness of breath, repetitive coughing, wheezing
• Heart	Weak pulse, faint, pale, blue, dizzy
• Gut	Repetitive vomiting, severe diarrhea
• Skin	Many hives over body, widespread redness
• Other	_____

INJECT EPINEPHRINE IMMEDIATELY

The severity of symptoms can quickly change**.** When both Epinephrine and Antihistamine are checked, **Epinephrine will be given first**. Antihistamine or other med given only if student alert and able to swallow.

DOSAGE

Epinephrine: Inject intramuscularly (**check one**) ☐ Epinephrine 0.15mg ☐ Epinephrine 0.3 mg

Antihistamine: give _____ **Other**: give _____
Medication/dose/route Medication/dose/route

Physician's Signature_____Start Date: _____*End Date: _____
(Required)

Physician's name (printed) _____ Phone _____ Fax number _____

☐ **This student is both capable and responsible to self-administer the Epinephrine. This student may carry his/her Epinephrine**:

_____ _____ _____

Physician's Signature and Date	Parent Signature and Date	Student's Signature and Date

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

_____ _____ _____

SHA Signature and Date | Name of PHN Contacted by Phone & Date | PHN Signature and Date

Please note: This form replaces the *Health Alert, Severe Allergy* form and the use of *Authorization for Medication* for severe allergy medication orders only. Revised 6/15

TURN FORM OVER

Students with conditions that may substantially impact school functioning (including medical or psychological conditions) may be eligible for accommodations under federal laws, specifically Section 504 of the Rehabilitation Act. Students or parents who are concerned that a diagnosed condition may interfere with the student's ability to access or participate in school activities should discuss their concerns with a school administrator.

STEP 2: EMERGENCY CALLS (To be completed by parent/guardian)

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call **Parent/Guardian** or Emergency contact(s):

Name/Relationship	**Phone Number(s)**	
a._____	1._____	2._____
b._____	1._____	2._____
c._____	1._____	2._____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel, including unlicensed persons, to give the medication described above as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools, Arlington Department of Human Services, Arlington County, and any of its officers, staff members, or agents from any lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student by administration of this medication to him/her as requested by the parents, including any adverse effects to the medication.

Parent/Guardian Signature_____ **Date**_____

*Order form good for one school year including Summer School. Medication expiration dates: _____

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

_____	_____	_____
SHA Signature and Date	Name of PHN Contacted by Phone & Date	PHN Signature and Date

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Orden Médica/Plan de Acción Para Alergias Severas

FOTO DEL NIÑO AQUI

NOMBRE DEL ESTUDIANTE: _____ **FECHA de NAC:** _____**Grado:**_____

ALERGIA A:

_____

Asmático **SI*** ☐ **No** ☐ ***Alto riesgo de reacciones severas**

STEP 1: TREATMENT (This section to be completed by authorizing physician - Esta sección debe ser completada por el médico)

Symptoms: **Give Checked Medications**

- If exposure to allergen (e.g., sting, food ingested), but has no symptoms ☐ Epinephrine ☐ Antihistamine

MILD SYMPTOMS

• Mouth	Itchy runny nose, sneezing	Epinephrine ☐ Antihistamine ☐
• Skin	A few hives, mild itch	Epinephrine ☐ Antihistamine ☐
• Gut	Mild nausea/discomfort	Epinephrine ☐ Antihistamine ☐

SEVERE SYMPTOMS - Potentially Life-Threatening

- Throat — Tightening of throat, hoarseness, hacking cough
- Lung — Shortness of breath, repetitive coughing, wheezing
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INJECT EPINEPRINE IMMEDIATELY

- Other _____
- The severity of symptoms can quickly change. When both Epinephrine and Antihistamine are checked, **Epinephrine will be given first**. Antihistamine or other med given only if student alert and able to swallow.

DOSAGE

Epinephrine: Inject intramuscularly (**check one**) ☐ Epinephrine 0.15mg ☐ Epinephrine 0.3 mg

Antihistamine: give _____ **Other**: give _____
Medication/dose/route Medication/dose/route

Physician's Signature_____Start Date: _____*End Date: _____
(Required)

Physician's name (printed) _____ Phone _____ Fax number _____

☐ **This student is both capable and responsible to self-administer the Epinephrine. This student may carry his/her Epinephrine**:

_____	_____	_____
Physician's Signature and Date	Parent Signature and Date	Student's Signature and Date

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

_____	_____	_____
SHA Signature and Date	Name of PHN Contacted by Phone & Date	PHN Signature and Date

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Siga al reverso

STEP 2/PASO 2: EMERGENCY CALLS (To be completed by parent/guardian) (LLAMADAS DE EMERGENCIA (Completado por el padre o encargado)

1. **Call 911** State that an allergic reaction has been treated, and additional epinephrine may be needed. **(Llame al l 911.** Diga que una reacción alérgica ha sido tratada y que es possible que Epinefrina adicional sea necesaria).
2. Call **Parent/Guardian** or Emergency contact(s): (Llamar **al Padre/Encargado** o Contacto(s) de Emergencia:)

Nombre/Relación **Teléfono(s)**

a._____1._____ 2._____
b._____1._____ 2._____
c._____1._____ 2._____

AUNQUE NO PUEDA LOCALIZAR AL PADRE/GUARDIAN,
¡NO VACILE EN DAR EL MEDICAMENTO O LLEVAR AL ESTUDIANTE AL HOSPITAL!

Por la presente autorizo al personal del Departamento de Servicios Humanos y de las Escuelas Públicas del Condado de Arlington incluyendo personal no licenciado, a dar medicinas de la forma indicada en esta autorización. Yo estoy de acuerdo en liberar, indemnizar y dejar sin responsabilidad a las Escuelas Públicas, el Departamento de Servicios Humanos, al Condado de Arlington y cualquiera de sus oficiales, miembros del personal, o agentes, en un juicio legal, reclamo, gasto, demanda o acción, etc., contra ellos por ayudar a este estudiante con la administración de medicamentos solicitado por los padres, incluyendo cualquier efecto secundario de la medicina.

Firma del Padre/Encargado_____ **Fecha**_____

* Orden válida por un año escolar incluyendo la escuela de verano.

Fecha de Expiración de los medicamentos: _____

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

_____ _____ _____
SHA Signature and Date Name of PHN Contacted by Phone & Date PHN Signature and Date

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Siga al reverso