Allergy Treatment Plan

School District of Mauston
Revised 04/2018

STUDENT: _____ Birthdate: _____ School: _____ Grade/Class:_____
Physician: _____
Allergy to:_____
if exposed by being stung, ingesting, inhaling, skin contact
(Circle above as indicated) Wash w/ soap & water if exposed Asthmatic: no or yes* (* higher risk for severe reaction)

Epinephrine medication: (Circle appropriate) Give by injection
EpiPen EpiPen Junior Twinject 0.3 mg Twinject 0.15 mg Auvi-Q 0.3 mg Auvi-Q 0.15 mg

Antihistamine: Benadryl / Diphenhydramine _____mg, Other_____ Give orally_____

Treat as indicated below

If exposed, but no symptoms		Antihistamine	Epinephrine/call 911 _____
Mouth	Itching, tingling	Antihistamine	Epinephrine/call 911 _____
Skin	Hives, itchy rash, swelling (except as below)	Antihistamine	Epinephrine/call 911 _____
Swelling	Swelling of lips, tongue, mouth or face	Antihistamine	Epinephrine/call 911 _____
Gut	Nausea, abdominal cramps, vomiting, diarrhea	Antihistamine	Epinephrine/call 911 _____
Throat **	Tightness of throat, hoarseness, hacking cough	Antihistamine	Epinephrine/call 911 _____
Lung **	Shortness of breath, repetitive coughing, wheezing	Antihistamine	Epinephrine/call 911 _____
Heart **	Fainting, pale, blue, weak or thready pulse, low BP	Antihistamine	Epinephrine/call 911 _____
Other **_____		Antihistamine	Epinephrine/call 911 _____

** Potentially Life-threatening. Severity of symptoms can change quickly. CALL 9-1-1!

Any additional directions:_____

PARENT/GUARDIAN CONSENT:

- ❖ This student is capable of self-administration and may carry medication & self-administer in school (Epi-Pen and/or Benadryl) Yes___ No____
- ❖ I request and authorize that this medication be administered at school by school personnel.
- ❖ I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- ❖ This order is in effect for this school year unless otherwise indicated.
- ❖ I will obtain a new physician's order and notify the school in writing for any changes.
- ❖ I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- ❖ I further understand that parent/guardian/responsible adult should deliver all medication to the school.
- ❖ I give my permission to have my child's photo displayed on this form.
- ❖ I understand that non-medically trained school personnel will give medication.
- ❖ 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.

_____ _____ _____ _____
Signature of Parent/Legal Guardian Telephone Home Work/ Phone Date

PHYSICIAN ORDER: The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication will be given by non-medically trained school personnel. Please contact me if the following symptoms occur:_____
Student & parent/guardian have been instructed and student may carry medication & **self-administer** in school. Yes_____ No_____

Physician Name: _____ Clinic:_____ Fax #: _____

Address:_____Phone #: _____

Physician Signature: _____ Date: _____