AUBURN UNION SCHOOL DISTRICT
255 EPPERLE LANE
AUBURN, CA 95603
PHONE 530.885.7242 FAX 885.5170

ALLERGY/ANAPHYLAXIS ACTION PLAN

Dear Parent/Guardian,
According to your child's health records, he/she has a severe allergy and/or history of an anaphylactic reaction. In order to administer emergency medication at school, Part I (Physician section) and Part II (Parent section) of this form must be completed and returned to the district nurse. If you have any questions, please contact Jenny Serrano, District Nurse (jserrano@auburn.k12.ca.us)

Student Name:		Date of Birth:
School:	Grade:	School Year:

Allergic Reaction To: ______________________________________ History of Asthma? ☐ Yes (more risk of severe reaction) ☐ No

PART I: PHYSICIAN SECTION

HEALTHCARE PROVIDER ORDERS (To be completed by provider authorizing treatment)		
Symptoms	Give Checked Medication	
If a food allergen has been ingested, but no symptoms	☐ Epinephrine	☐ Antihistamine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin – Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut – Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat - Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung - Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart - Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other:	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine	☐ Antihistamine

MEDICATIONS ORDERED		
Medication	Dose/Route	Time
Epinephrine Auto-Injector	☐33-66 pounds -Jr Strength 0.15mg IM ☐ >66 pounds – 0.3mg IM ☐Other:	☐1st dose as needed ☐2nd dose in ___ minutes if symptoms are not resolved ☐Other: _________________________
Antihistamine Name:______________________	☐ 12.5 mg PO ☐ 37.5mg PO ☐ 25mg PO ☐ 50 mg PO ☐ Other:___________________	☐As needed ☐Other: __________________________
Additional Medication:		

CONTINUED ON OTHER SIDE

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ALLERGY/ANAPHYLAXIS ACTION PLAN (CONTINUED)

SELF ADMINISTRATION AUTHORIZATION/APPROVAL for emergency medication use only	
Has student been instructed on correct use and may carry/self-administer? **NOTE**: **The physician, parent/guardian and school nurse must agree, check and sign here** (*District Nurse has final approval for self-administering and/or carrying medication by student at school*)**:**	
Prescriber's authorization for self administration: ☐ Y ☐ N	***Signature/date***
Parent/Guardian authorization for self administration: ☐ Y ☐ N	***Signature/date***
District Nurse authorization for self administration: ☐ Y ☐ N	***Signature/date***

HEALTH CARE PROVIDER AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL	
My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the District Nurse. This authorization is for a maximum of one (1) year. If changes are indicated, I will provide new written authorization. (May be faxed)	
Physician Signature:	**Date:**
Physician Name:	
Address:	
Telephone:	

PART II: PARENT SECTION

PARENT CONSENT AND AUTHORIZATION	
I(we), the undersigned, the parent(s)/guardians of the above named student, request my (our) student be assisted with or administered the following medication in accordance with the California Education Code 49423.5 and Board Policy/Administrative Regulation. I agree to: 1. Provide all medications, supplies and equipment. 2. Notify the school if there is a change in the student's health status or attending physician. 3. Notify the school immediately and provide a new consent for any changes in the doctor's orders. 4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP. I authorize the District Nurse to communicate with the Authorized Health Care Provider when necessary in regards to this specific medication and medical condition. I will be provided with a copy of my child's completed ISHP.	
Parent/Guardian Signature:	**Date:**
Parent/Guardian Name:	

Principal's Signature:___________________________________ **Date:**____________________

District Nurse Signature:________________________________ **Date:**____________________