

**WILLIAMSBURG SCHOOLS ALLERGY ACTION PLAN
MEDICATION ORDER FORM & PARENT CONSENT**

Student _____ D.O.B. _____ Grade _____

ALLERGIC TO: _____ **BY: Injection**

ALLERGY HISTORY

(To Be Completed By Health Care Provider)

Does the child have a documented anaphylactic reaction? Yes No If yes, when _____

What were the child's past allergy reaction symptoms? _____

Does the child have asthma? Yes No (higher risk for severe reaction in an asthmatic child)

PHYSICIAN'S ORDER AND TREATMENT PLAN

(Circle medication and dosage)

If the child ingests the food allergen please be prepared to administer the following medications.

Epinephrine (give intramuscularly in thigh) 0.15 mg 0.3 mg Other _____
Repeat epinephrine if symptoms persist and ambulance has not arrived? Yes No

Antihistamine (give orally, if student can swallow) 12.5 mg 25 mg 50 mg

Albuterol Inhaler _____

- If this child is stung, give epinephrine immediately. Do not wait for symptoms.**
- If this child is stung, watch for symptoms that may require epinephrine.
See Treatment Plan below.**

TREATMENT PLAN

If symptoms of:

MOUTH	Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
SKIN	Hives, itching, 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 pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
OTHER	_____	Epinephrine	Antihistamine
If reaction progresses (several areas above affected) repeat administration:		Epinephrine	Antihistamine

I authorize that this child is age appropriate to carry and self-administer his/her own EpiPen if needed. Yes No

Physician Signature _____ Date _____

Physician Printed Name _____ Phone _____

TRANSPORT/EMERGENCY/PARENT CONSENT

If epinephrine administered call 911 IMMEDIATELY

Transport my child via ambulance to (hospital preference) _____

If a parent/guardian cannot be reached the child will be transported to the preferred hospital listed.

- I give consent for the school nurse/delegated and trained personnel to implement the plan above and administer medications as prescribed by my child's physician.
- I give consent for school & bus personnel to be made aware of my child's allergy and the above treatment plan in order to quickly recognize allergic symptoms, retrieve emergency medication and get prompt care.
- I agree with above treatment plan as prescribed by my child's physician and will update the school nurse if there are any changes in my child's treatment plan or allergy status.

Parent/Signature _____

Date _____