

**LINCOLN PARK MIDDLE SCHOOL**  
**Severe Allergic Reaction/Anaphylaxis/Individual Action Plan/Physician Orders**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Delegates \_\_\_\_\_

The above named student is sensitive to the following allergens which may trigger anaphylactic episode:

\_\_\_\_\_

**Action**

If one of the above was ingested or student exposed call the nurse or have an adult bring the student to the Health Office. Notify parent immediately.

If nurse is available – monitor the student for at least 30 minutes for signs and symptoms of anaphylaxis.

If no nurse is available - stay with student, call delegate, notify parent.

Epi-Pen may be administered by nurse or delegate as ordered for the following signs and symptoms (circle):

Respiratory-wheezing, persistent coughing, stridor, shortness of breath, tightness in chest or throat, absence of breathing

Mouth – swelling throat, tongue, lips, face

Skin – diffuse hives, widespread itching

Abdominal symptoms – vomiting, severe diarrhea, cramps

Circulatory – Tachycardia (rapid, thready pulse), fainting, loss of consciousness

Other \_\_\_\_\_

**Call 911 – state there is an allergic reaction and Paramedics are needed**

**Begin CPR if absence of breathing or pulse**

**Notify, parent, building administrator, physician**

For Mild Distress – circle symptom: itching, few hives, some nausea, \_\_\_\_\_

Nurse may administer \_\_\_\_\_

Medication

Dose

**EpiPen – Physician’s Order**

Medication

Dose

Conditions under which self-medication which take place:

\_\_\_\_\_ Independently The child has been trained and is proficient in self-administering of medication

\_\_\_\_\_ Under the supervision of the school nurse

Medication should be \_\_\_ in the possession of the student

\_\_\_ stored in the health office

\_\_\_\_\_ I have reviewed the Emergency Health Care Plan and approved it as written

\_\_\_\_\_ I have reviewed the Emergency Health Care Plan and approve of it with the attached amendments.

\_\_\_\_\_ I do not approve the Emergency Health Care Plan. A substitute is attached.

PHYSICIANS’ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**I give my permission for my child to self-administer the medication described above. I understand and acknowledge that the Board of Education, collectively and individually, as well as its employees or agents shall incur no liability whatsoever as a result of any injury, whether foreseen or unforeseen, arising from the self-administration of medication by my child. I also agree to indemnify and hold harmless the Board of Education, collectively and individually, as well as its employees or agents for legal fees, costs and any potential damages concerning self-administration of this medication arising from any claims brought by the above-named child, individually or by a guardian, or anyone else.**

Parent/Guardian Signature (1) \_\_\_\_\_ Date \_\_\_\_\_

(2) \_\_\_\_\_ Date \_\_\_\_\_

Nurse Signature \_\_\_\_\_