ALLERGY EMERGENCY ACTION PLAN Newmarket School District
Parent Permission for Treatment **Date:**

Student: _____ D.O.B._____Teacher _____

Allergy to:_____ Date of last reaction:_____

Describe the specific reaction your child had and treatment given:_____
_____

Allergic to ingestion touch both

If an epinephrine is given and an ambulance is called, which hospital would you like your child to be transported to? _____Exeter Hospital ____ Portsmouth Hospital

Please provide at least two emergency contacts if an emergency:

Call first: Name: _____ Relationship:_____
Home:_____ Cell:_____ Work:_____

Call second: Name: _____ Relationship:_____
Home:_____ Cell:_____ Work:_____

Other: Name: _____ Relationship:_____
Home:_____ Cell:_____ Work:_____

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PHYSICIAN MEDICAL AUTHORIZATION

Epinephrine: ____ EpiPen ____ EpiPen Jr. ___Auvi-Q ____ Benadryl ____ mg.

Give epinephrine for the following symptoms and CALL 911
____ Contact with allergen, but no symptoms

____ Contact with the allergen and one or more of the following anaphylaxis symptoms

- **LUNG: Short of breath, coughing, itchy throat, wheeze**
- **HEART: Restlessness/ Anxiety/ Fainting, pale, blue, weak pulse, dizzy**
- **THROAT: Tight, hoarseness, trouble breathing, swallowing**
- **MOUTH: Itching and swelling of face, lips, tongue**
- **SKIN: Generalized hives, swelling, redness**
- **GUT: Nausea, abdominal pain, vomiting, diarrhea**

Other:_____

_____ _____ _____ _____
Parent Signature Date Physician's Name (print) Date

_____
Physician's Signature

PARENT TO COMPLETE

Parental Responsibilities:

• The parent or guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the school the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.

• The parent/guardian, or other designated adult will deliver to the school and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given.

• If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to the school. The parent or guardian will complete an updated Epinephrine Auto Injector (EAI) Authorization Form/Emergency Action Plan (this form) before the designated staff can administer the updated Epinephrine Auto Injector (EAI) medication prescription.

Parent/Guardian Authorization

☐ I authorize my child to carry the prescribed medication described above.
My student is responsible for, and capable of, possessing an epinephrine auto injector per UCA 26-41-104. My child and I understand there are serious consequences for sharing any medication with others.

☐ I authorize my student to self-carry and self-administer EAI if needed, when able and appropriate.

☐ I authorize my student to self-carry, but not self-administer EAI.

☐ I do not authorize my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in this Emergency Action Plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with allergy/anaphylaxis treatment, provided the personnel are following physician instruction as written in the emergency action plan above. Parents/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for allergy management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent Name (print):_____ Signature:_____
Home Number: _____Cell Number:_____
Emergency Contact:_____Relation:_____
Home Number: _____Cell Number:_____

SCHOOL NURSE (or principal designee if no school nurse)
☐ Signed by physician and parent ☐ Medication is appropriately labeled ☐ Medication log generated

Epinephrine is kept: ☐ Student Carries ☐ Backpack ☐ In Classroom ☐ Health Office ☐ Front Office ☐ Other:_____

Allergy & Anaphylaxis Emergency Action Plan (this form) distributed to need to know staff:
☐ Teacher(s) ☐ Transportation ☐ PE teacher(s) ☐ Front office/administration ☐ Other:
School Nurse Signature:_____
Date:_____