

**Saugus Union School District
Allergy/Anaphylaxis Action Plan, Physician's Orders**

Student's Name: _____ Date of Birth: _____
School: _____ Grade/Teacher: _____
Allergy: _____

Ingestion of _____ residue from _____ inhalation of _____

Reaction(s) previously noted: _____

Student has required: Epinephrine for previous allergic reaction yes no
Antihistamine for previous allergic reaction yes no

Asthma diagnosis: yes* no *Denotes higher risk for severe anaphylactic reaction. Meds at school for asthma

PHYSICIAN'S ORDERS AND ALLERGY/ANAPHYLAXIS ACTION PLAN

Signs/Symptoms of a Mild Allergic Reaction: GIVE ANTIHISTAMINE.

- Red, watery eyes, sneezing, runny nose
- Rash, hives, redness or swelling in localized area, itching
- Itchy/tingling mouth, throat or tongue **WITH NO OTHER SYMPTOMS**

Antihistamine: _____
(Medication name / dosage amount / route / frequency)

For: _____
(Indication)

If antihistamine is given for allergen exposure, parent must be called to pick student up from school.

Signs/Symptoms of a Severe Allergic Reaction/Anaphylaxis: GIVE EPINEPHRINE.

- Difficulty breathing, wheezing, repetitive or hacking cough
- Tightness in the throat, hoarseness, difficulty swallowing or drooling
- Swelling of the face, neck or tongue
- Confusion, weakness, dizziness, fainting or loss of consciousness (in association with above symptoms or with known exposure)
- Vomiting (in association with above symptoms or with known exposure)

The severity of symptoms can quickly change. All of the above symptoms can potentially progress to a life threatening situation.

Epinephrine auto injector*: Inject into lateral thigh muscle.

* Unlicensed school personnel may only give Epinephrine by auto injector, per Ed Code 49423

Epinephrine 0.15 mg via auto injector Epinephrine 0.3 mg via auto injector

For: _____
(Indication)

1. Staff will immediately call 911 when treating with Epinephrine and immediately call parent/guardian or emergency contacts.
2. Contact District Nurse.
3. If allergy is to insect sting, remove the stinger as soon as possible with the bee sting remover card and apply ice pack to sting area.
4. Epinephrine medication must go on all field trips; carried by parent or medication-trained staff member.

Physician Printed Name: _____

Physician's Signature: _____

Physician Phone: _____

Date: _____

↑ Physician's office stamp ↑

PARENTAL CONSENTS

Medication(s) prescribed is/are for current school year only.

I (parent) authorize personnel of the Saugus Union School District to assist my child with physician-prescribed medications to conform to California Ed. Code Section 49423. I authorize school staff to contact student's physician for clarification of orders. I authorize SUSU to share this allergy information with the food services vendor.

Seating Preference: Any change needs to be made in writing through the Health Office.

- I prefer that my child is seated away from those students having his/her food allergen:
 I have no preference as to where my child is seated while eating and assume liability.

- 1 student buffer at end of table
 Separate table (if available)

Parent Printed Name: _____ Parent Signature: _____

Parent Phone: _____ Date: _____

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