North Callaway R-1 School District ▪ 2023-2024 School Year

Allergy Action/Treatment Plan (O)

Student Name (Last, First, Middle)	Date of Birth	Weight	Grade

THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER (ADDITIONAL SPACE ON BACK)

Student history of asthma? Yes □ No □

History of anaphylaxis? Yes □ No □ If yes, date ______________________

Symptoms: Respiratory □ Skin □ GI □ Cardiovascular □ Neurologic

*** I certify the above student has the following SEVERE Allergy/Allergies (Specify):**

Does this student have the ability to:

Self-Manage: Yes □ No □

Recognize signs of allergic reaction: Yes □ No □

Recognize/avoid allergens independently: Yes □ No □

Comments regarding student abilities:

EPINEPHRINE AUTO-INJECTOR

Single Use Auto-Injectors:

Brand of Epinephrine:

Dose: 0.15 mg Auto-Injector □

Dose: 0.3 mg Auto-Injector □

Administer with antihistamine/medication (list below) □

ADMINISTER ON EXPOSURE, EVEN IF NO SYMPTOMS PRESENT? YES □ NO □

Auto-Injector PRN (Check All Applicable):

Respiratory: Shortness of Breath □ Wheezing □ Cough □

Heart: Weak Pulse □ Paleness/Blue □ Faint □ Dizziness □

GI: Throat Tightness □ Hoarseness □ Difficulty Swallowing □

Swelling of Tongue/Lips □ Vomiting/Diarrhea □

Skin: Hives □ Itching □ Redness □

Other (specify):

Select the Most Appropriate Option for Student:

Adult Dependent Student (Adult Must Administer) □

Supervised Student (Self-Admin Under Supervision) □

Independent Student (Can Self-Carry/Self-Admin) □ – **Physician:** I attest student has the ability to self-administer prescribed medication effectively ___________ (initial)

Parent: *Complete and return self-administration form for request to be honored.*

If no improvement, repeat in ___________minutes for a maximum of _____________times (3 maximum).

ORAL MEDICATIONS

Diphenhydramine:

Dosage: Route:

Frequency/Instructions if no improvement:

Oral Medication PRN (Check All Applicable):

Itchy/Runny Nose □ Itchy Mouth □ Mild Hives □ Sneezing □

Mildly Itchy Skin□ Mild Nausea/Discomfort □

Other (specify):

Other Oral Medication:

Name:

Dosage: Route:

Frequency:

Instructions if no improvement:

Oral Medication PRN (Check All Applicable):

Itchy/Runny Nose □ Itchy Mouth □ Mild Hives □ Sneezing □

Mildly Itchy Skin□ Mild Nausea/Discomfort □

Other (specify):

NOTICE: PHYSICIAN/PA/NP MUST ALSO COMPLETE MEDICATION AUTHORIZATION FORM FOR MEDICATIONS PRESCRIBED.

PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER INFORMATION

Physician/PA/NP Name (Please Print Legibly)	Signature & License # of Physician/PA/NP	Date

Physician/PA/NP Phone	Physician/PA/NP Address

CONTINUED ON OTHER SIDE

Allergy Action/Treatment Plan - Continued

PARENT/GUARDIAN/EMERGENCY CONTACTS (PARENT/GUARDIAN, PLEASE COMPLETE)

IF AN EMERGENCY OCCURS, WE WILL NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMERGENCY SERVICES REGARDLESS OF WHETHER PARENTS HAVE BEEN CONTACTED.

Parent/Guardian Name (Print)	Cell Number	Other Phone Number
Parent/Guardian Name (Print)	Cell Number	Other Phone Number
Other Contact Name (Print)	Cell Number	Other Phone Number

ADDITIONAL NOTES

Additional Physician/PA/NP Notes:

School Nurse Notes:

Parent/Guardian Authorization: I agree with the information and plan provided by my student's physician. I understand my student must also have a physician/PA/NP signed medication authorization on file with the school if medication has been ordered. If my student has food allergies requiring accommodation, I understand that I must also submit the medical statement for students requiring special meals. I also understand that if I wish my student to self-administer any emergency medication authorized by their doctor that I must submit a permission form for student to self-administer medication. Furthermore, I authorize the district to share relevant information regarding my student's allergy and treatment plan with anyone necessary to lessen the chances of, prevent, or treat a severe allergic reaction.

Parent/Guardian Name	Parent/Guardian Signature	Date
School Nurse Name	School Nurse Signature	Date