Groveport Madison Local School District
Allergy Action Plan

Student Name: _____ DOB: _____ Age: _____
Home Room Teacher: _____ Grade: _____
Parent/Guardian: _____ Phone (C): _____
Phone (H): _____ Phone (W): _____
Health Care Provider/Physician Treating Student for Allergy: _____
Phone # _____
Other Health Care Provider: _____
Phone: _____

Allergy To: _____

Asthma ☐ **Yes*** ☐ **No** *Higher risk for severe reaction
Additional health problems besides anaphylaxis: _____
_____
Medications: _____
_____

STEP 1 TREATMENT

Symptoms:	**Provide Care as Directed Below: Per Physician** (Prescribed Medication Authorization Form Must be on File)		
•If a food allergen has been ingested, but**, *no symptoms***:	Epinephrine	Antihistamine	Other/No Care needed at this time
•Mouth- Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine	Other/No Care needed at this time
•Skin- Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine	Other/No Care needed at this time
•Gut- Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine	Other/No Care needed at this time
•Throat- Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine	Other/No Care needed at this time
•Lung- Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine	Other/No Care needed at this time
•Heart- decrease in pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine	Other/No Care needed at this time
•Other- _____ _____	Epinephrine	Antihistamine	Other/No Care needed at this time

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

STEP 2 EMERGENCY CALLS

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed
2. Dr. _____ at _____

Comments/Special Instructions ***(regarding school activities, sports, trips, etc.)***

_____
_____

Physician Signature: _____ **Date:** _____

☑ I authorize the licensed healthcare professional to talk with the prescriber to clarify Allergy Action Plan.

Parent/Guardian Signature: _____ **Date:** _____

Please attach an extra sheet of paper for additional charting space

Adopted from Food Safe Schools. 5/2012

Groveport Madison Local School District
Prescribed Medication Authorization

Student Information

Student name			Date of birth
Student address			
School	Grade/Class	Teacher	School year
List any known drug allergies/reactions		Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		

Epinephrine Autoinjector
- ❑ Not applicable
- ❑ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Asthma Inhaler
- ❑ Not applicable
- ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.

Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718
a) To the student for whom it is prescribed (that should be reported to the prescriber)

b) To a student for whom it is not prescribed who receives a dose

Other medication instructions
Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No

Prescriber signature	Date	Phone	Fax

Prescriber name (print)

Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone