Oklahoma City Public Schools
ALLERGY & ANAPHYLAXIS EMERGENCY PLAN

School Year:

School:	**Teacher:**	**Grade:**
Student Name		**Date of Birth**
Parent/Guardian	**Parent/Guardian Phone**	**Parent Guardian E-Mail**
Emegency Contact Name	**Emergency Contact Phone**	
Student has allergy to:		
Student has asthma ☐ Yes ☐ No	**Student has had anaphylaxis ☐ Yes ☐ No**	

For Severe Allergy & Anaphylaxis
What to look for

If student has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom", confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION:** If this box is checked, student has an extremely severe allergy to an insect sting or the following food(s):_____. Even if student has MILD symptoms after a sting or eating these foods, give epinephrine.

Give Epinephrine!
What to do

1. Inject epinephrine right away! Note time when given.
2. Call 911.
3. Stay with student and:
   - Call parents & School Nurse
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes
4. Give other medication, if prescribed. Do not use other medication in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If student has had any mild symptoms, **monitor student.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor student
What to do

Stay with student and

- Watch student closely
- Give antihistamine (if prescribed)
- Call parents & School Nurse
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine (See "For Severe Allergy & Anaphylaxis

*****A completed Authorization for Medication form must be completed and attached for medication at school*****

Medications/Doses

Epinephrine (list type) _____ Dose: ☐ 0.15 mg ☐ 0.30 mg

Antihistamine, by mouth (type & dose)_____

Other (example-inhaler/bronchodilator if student has asthma) _____

Physician/Licensed Health Provider _____Date_____
Signature Phone _____

I give permission for school personnel to follow this plan, administer medication and care for my child following OKCPS Policy and contact my provider if necessary**. I understand this Allergy Action Plan must match the Authorization for Medication form completed by my Licensed Healthcare Provider.** I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I understand this plan is valid for this school year only and must be renewed at the beginning of each school year.

☐ I understand and acknowledge the above statement. ☐ I do not understand and acknowledge the above statement.

Parent/Guardian Signature_____Date_____

Oklahoma City Public Schools
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student_____ **Birthdate** _____ **Grade**_____ **School Year** _____
School_____ **Teacher**_____ **Date received** _____

- **TO BE COMPLETED BY THE LICENSED PHYSICIAN OR PRESCRIBER**

1. **Reason for medication** _____
2. **Name of medication** _____
3. **Dosage** _____
4. **Time to be administered** _____
5. **Duration (week, month, indefinite, etc.)** _____
6. **Side Effects:** ☐ **None Expected** ☐ **Specify** _____
   _____
7. **Form of medication/treatment: Tablet**____ **Liquid**____ **Inhaler**____ **Injection**____ **Nebulizer**____ **Other**_____
8. **Special storage requirements: None** _____ **Refrigerate** _____

_____ _____ _____
Licensed Prescriber Signature **Name (please print)** **Date**

_____ _____ _____
Address **Phone** **Fax**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. "Over the counter medication" must be in the original, unopened container. All medication must be brought to school by an adult. **Substances not approved by the FDA will not be stored nor administered by school personnel.** I further understand that I will be responsible for picking up any remaining medication at the end of the school year; medication will NOT be sent home with students. Any medication remaining after the school year has ended will be discarded utilizing proper procedure. The school nurse may consult with the prescriber regarding this prescription. Changes to the time and/or dosage of the medication require written authorization from the licensed prescriber and parent/guardian.

☐ **I understand and acknowledge the above statement.** ☐ **I do not understand and acknowledge the above statement.**

_____ _____
Parent/Guardian Signature **Date**

COMPLETE FOR SELF-ADMINISTRATION AND/OR SELF CARRY OF
ASTHMA, ANAPHYLAXIS, REPLACEMENT PANCREATIC ENZYME AND DIABETES MEDICATION ONLY

TO BE COMPLETED BY THE LICENSED PHYSICIAN/PRESCRIBER:

- **This student has been instructed and is capable and responsible to self-administer this medication: Yes** ____ **No** ____
- **This student may carry this medication on their person: Yes**____ **No**____

_____ _____
Licensed Prescriber Signature (Required) **Date**

- **TO BE COMPLETED BY THE PARENT/GUARDIAN:**

Authorization for Self-Administration and/or Self-Carry of Medication

THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION AND/OR SELF-CARRY OF MEDICATION BY MY STUDENT/CHILD. PURSUANT TO OKLAHOMA LAW, I UNDERSTAND I AM *REQUIRED TO PROVIDE THE SCHOOL WITH AN EMERGENCY SUPPLY OF THE MEDICATION(S).*

_____ _____
Parent/Guardian Signature **Date**

I will not knowingly share my medication with another student.

_____ _____
Student Signature **Date**