San Marcos Unified School District School: _____

Allergy and Anaphylaxis Emergency Plan

Name:	Date of Birth:	Weight: lbs / kg
Date of Plan:	Age:	
ALLERGIES:		

Child has asthma: yes / no (if yes, higher chance of a severe reaction)
Child has had anaphylaxis: yes / no (if yes, higher chance of a severe reaction)
Child may carry medicine: yes / no
Child may give him/herself medicine: yes / no (if child refuses, an adult must give medicine)

Attach child's photo

☐ **The "Always-Epinephrine" Option:** If checked, **give epinephrine** immediately, if the child has ANY symptom (mild or severe) after a sting or eating a food listed above. (Option advised for those schools where a nurse is not always present.)

****IF IN DOUBT, GIVE EPINEPHRINE!** ANAPHYLAXIS is a potentially life-threatening, severe allergic reaction

For SEVERE Allergy or Anaphylaxis **What to look for:**	**Give EPINEPHRINE!** **What to do:**
If child has ANY of these symptoms after eating a food or having a sting, **give epinephrine** ➢ Breathing: trouble breathing, wheeze, cough ➢ Throat: tight or hoarse throat, trouble swallowing or speaking ➢ Brain: confusion, agitation, dizziness, fainting, unresponsiveness ➢ Gut: severe stomach pain, vomiting, diarrhea ➢ Mouth: swelling of lips or tongue that affects breathing ➢ Skin: many hives or redness over body, face color is pale or blue	1. **Inject epinephrine right away!** Note the time. 2. Call 911 • Ask for ambulance with epinephrine • Tell rescue squad when epinephrine was given 3. Stay with child and: • Call parents • **Give a second dose of epinephrine** if symptoms worsen or do not get better in 5 minutes • Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on their side 4. Give other medicine (e.g. antihistamine, inhaler) if prescribed. Do not use other medicine in place of epinephrine.

For MILD Allergic Reaction **What to look for:**	**Give Antihistamine and Monitor the Child** **What to do:**
If child has mild symptoms, or no symptoms but a sting or ingestion of the food is suspected, give antihistamine and monitor the child. Mild symptoms may include: ➢ Skin: a few hives, mild rash, mild swelling, OR ➢ Mouth/nose/eyes: itching, rubbing, sneezing, OR ➢ Gut: mild stomach pain, nausea or discomfort Note: if the child has more than one mild symptom area affected, **give epinephrine**	1. Give antihistamine if prescribed 2. **If in doubt, give epinephrine** 3. Call parents 4. Watch child closely for 4 hours 5. **If symptoms worsen, give epinephrine** (See "For SEVERE Allergy and Anaphylaxis")

Medicine/Doses

Epinephrine (intramuscular in thigh): □ 0.1 mg □ 0.15 mg □ 0.30 mg
Antihistamine (by mouth): □ Diphenhydramine _____mg (_____ml) □ Other_____: _____ mg (_____ml)
Other medications: □ Albuterol 4 puffs □ other: _____

PROVIDER Signature **Date** **Name (printed)** **Phone** **NPI#**

PARENT/GUARDIAN Signature **Date** **Name (printed)** **Phone**

I authorize the school to follow Plan and contact the Health Care Provider, and release the school district and personnel from civil liability

Reviewed by School Nurse: _____Date:_____ San Diego County v2018_09

San Marcos Unified School District

School: _____

Allergy and Anaphylaxis Emergency Plan

Child's name: _____ Date of Plan: _____

Additional Instructions:

Contacts

Doctor name (print): _____ Office Phone: (___) _____-_____

Office Address: _____ Office Fax: (___) _____-_____

_____

_____

Parent/Guardian name (print): _____ Phone: _____

Parent/Guardian name (print) : _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

SAN MARCOS
UNIFIED SCHOOL DISTRICT
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NURSING & HEALTH SERVICES

School:_____ School Year:_____

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Education Code Section 49423; 5 California Code of Regulations 603

Any pupil who is required to take, during the regular school day, medication prescribed for him/her by a physician, may be assisted by a school nurse or other designated school district personnel if the district receives:

1. A written statement from a physician licensed in the State of California, or physician assistant, detailing the name of the medication, method, amount, and time schedules by which such medication is to be taken.

2. Written authorization from the parent/guardian of the pupil indicating the desire that school personnel assist the pupil in the matters set forth in the Physician's Statement.

This authorization is valid only for the current school year. In addition, if any of the conditions in the Physician's Statement changes during the school year, a new Physician's Statement and parent/guardian authorization form must be submitted.

This portion to be completed by parent/guardian.

I request that a school nurse or other designated school district personnel administer medication, or assist in the administration of medication, as directed by my child's physician.

_____ _____
Pupil's Name Grade

I authorize the school nurse or other designated school district personnel to communicate directly with my child's physician's office, as may be necessary, regarding the Physician's Statement. I understand what school personnel will do to assist in administering medication to my child.

I understand that I have certain responsibilities to enable school personnel to assist in the administration of medication to my child. This includes ensuring that a current, authorized Physician's Statement has been delivered to the school nurse or other authorized personnel. This also includes ensuring that only medication prescribed by my child's physician and listed on the Physician's Statement will be brought to the school. I understand that medication should be in containers that are clearly marked with the name of the pupil, the name of the prescribing physician, the name of the medication, and the amount of medication. Over the counter medication must be in the original container and labeled with the student's name.

I understand that I may terminate consent for the administration of medication to my child at any time by notifying the school nurse in writing.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Home Telephone Number Work Telephone Number

SAN MARCOS
UNIFIED SCHOOL DISTRICT
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NURSING & HEALTH SERVICES

Escuela:_____ Año escolar:_____

AUTORIZACIÓN PARA LA ADMINISTRACIÓN DE MEDICAMENTO

Código de Educación Sección 49423; 5 California Código de Regulaciones 603

Cualquier alumno que deba recibir, durante el día escolar, medicamento prescrito por su médico, puede ser asistido por una enfermera escolar u otro miembro designado del personal del Distrito, si el distrito recibe:

1. Una declaración escrita por un médico con licencia del estado de California, o su asistente, detallando el nombre del medicamento, el método, la cantidad y el horario para administrar el medicamento.

2. La autorización por el padre/tutor del alumno indicando el deseo de que el personal de la escuela asista al estudiante con relación a lo descrito en la declaración del médico.

Esta declaración es válida únicamente para el año escolar actual. Además, si cualquiera de las condiciones descritas en la declaración del médico cambia se debe de presentar una nueva declaración del médico y una nueva autorización del padre/tutor.

Está porción debe de ser llenada por el padre/tutor

Solicito que la enfermera escolar u otro miembro del personal del Distrito administre el medicamento, o asista durante la administración del medicamento tal y como lo indica el médico de mi hijo(a).

_____ _____
Nombre del alumno Grado

Autorizo que la enfermera escolar u otro miembro designado del personal del Distrito se comunique directamente al consultorio del médico de mi hijo(a), como sea necesario, con relación a la declaración del médico. Entiendo que es lo que el personal escolar hará para asistir en la administración del medicamento a mi hijo(a).

Entiendo que tengo ciertas responsabilidades en posibilitar al personal escolar para asistir en el administración del medicamento a mi hijo(a). Esto incluye asegurarme de que la declaración del médico actualizada haya sido entregada a la enfermera escolar u otro personal autorizado. Esto también incluye el asegurarme que sólo el medicamento prescrito y detallado en la declaración del médico sea traído a la escuela. Entiendo que el medicamento debe de estar en recipientes que estén claramente identificados con el nombre del alumno, el nombre del médico que prescribió el medicamento, el nombre del medicamento y la cantidad del medicamento. Los medicamentos sin receta deben de estar en su recipiente original y etiquetados con el nombre del estudiante.

Entiendo que puedo rescindir del consentimiento de la administración del medicamento a mi hijo(a) en cualquier momento por medio de la notificación por escrito a la enfermera escolar.

_____ _____
Firma del padre/tutor Fecha

_____ _____
Teléfono de casa Teléfono del trabajo