MADISON COUNTY SCHOOLS **SCHOOL YEAR:** _____

SCHOOL MANAGEMENT PLAN - SEVERE ALLERGY TO: _____

Student also has ASTHMA? □ YES □ NO

Section 1 – Parent (Please Print):

Student Name: _____ DOB: _____ Wt: _____

Other allergies/triggers: _____ School: _____ Gr. _____

Medications Taken at Home: _____

Bus Transportation to and from school: Bus # a.m. _____ Bus # p.m. ____

Parent Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Emergency Contact: _____ (Name) _____ (Cell #) _____ (Home #) _____ (Work #)

Physician: _____ Phone #: _____

Preferred Hospital in Case of Emergency: _____

Insurance Provider: _____ (optional) Policy/Group # _____ (optional)

SECTION II –Physician (Please Print)

IF YOU SEE THIS…	DO THIS…
Contact with or ingestion of allergen with no symptoms	1. Administer medication? ❑ Yes ❑ No Medication: _____ Medication dosage:_____ 2. Call parent or emergency contact 3. Observe student for ____minutes before return to class 4. Recheck student in 1 hour.
Symptoms of mild or early allergic reaction: • Itching • Hives • ***No Respiratory Distress***	1. Administer medication? ❑ Yes ❑ No Medication: _____ Medication Dosage: _____ 2. Other: _____
Symptoms of **severe allergic reaction**: • Mouth tingling • Respiratory distress: cough, wheeze, stridor • Weak pulse, low BP, pallor • Abdominal cramps, nausea	Administer Epinephrine? ❑Yes ❑ No ❑ Epipen: ❑0.3 mg ❑0.15 mg ❑ Twinject: ❑0.3 mg ❑0.15 mg ❑ Auvi-Q: ❑0.3 mg ❑ 0.15 mg **Follow instructions for administration as illustrated on box.** **1. Call 9-1-1** 2. Call parent/emergency contact 3. Remain with student until EMS personnel arrive 4. Give used autoinjector, to EMS personnel, if administered

*** ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER.**

When on field trips, the autoinjector should not be left in a backpack on the bus or with a teacher not with the student.

If student "self-carries" and "self-administers" medication, may a "back up" dose be kept with school nurse? ❑ Yes ❑ No

The severity of symptoms can change quickly and potentially progress to a life threatening situation.

I UNDERSTAND AND AGREE WITH THIS MANAGEMENT PLAN:

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.

I give permission for the release of my child's medical information, in the event of an emergency.

Physician/Prescriber's Signature Date

School Nurse's Signature Date

Parent's Signature Date

Staff Signature (s) Date

FOR SCHOOL NURSE USE ONLY

Medication	Self Carry?	Self Administer?	Expiration	Location of Medication

Revised: 07/2014