School District of Crandon

Allergy Treatment Plan

2024-2025

Allergy Treatment Plan must be completed along with the Medical Authorization Form. All portions of this medical treatment plan must be completed before medication/procedure will be administered by school district personnel.

Student Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Student has an allergy to: _____

Student has asthma. ☐ **Yes** ☐ **No (If yes, higher chance of severe reaction)**

Student has had anaphylaxis. ☐ **Yes** ☐ **No**

DOSAGE

Epinephrine: (circle appropriate) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg Other _____

To be administered: intramuscularly

Antihistamine (medication/dose/route): _____

Possible Side Effects: _____

ANAPHYLAXIS IS A POTENTIALLY LIFE-THREATENING, SEVERE ALLERGIC REACTION. IF IN DOUBT, GIVE EPINEPHRINE.

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)*	
• If a food allergen has been ingested, but no symptoms:		□Epinephrine	□Antihistamine
• Mouth:	Itching, tingling, or swelling of lips, tongue, mouth	□Epinephrine	□Antihistamine
• Skin:	Hives, itchy rash, swelling of the face or extremities	□Epinephrine	□Antihistamine
• Gut:	Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine	□Antihistamine
• Throat†:	Tightening of throat, hoarseness, hacking cough	□Epinephrine	□Antihistamine
• Lung†:	Shortness of breath, repetitive coughing, wheezing	□Epinephrine	□Antihistamine
• Heart†:	Thready pulse, low blood pressure, fainting, pale, blue	□Epinephrine	□Antihistamine
• Other†:	_____	□Epinephrine	□Antihistamine
• If reaction is progressing (several of the above areas affected), give:		□Epinephrine	□Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

The School District of Crandon has my written consent to administer medication/procedure as indicated in this treatment plan. I agree to hold the School District, its employees or agents who are acting on this request within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

- I will supply medication in its original, updated, properly labeled container.
- I will obtain a new physician's order and notify the school in writing of any changes.
- I authorize the school nurse to exchange information verbally or in writing with my student's physician regarding this medication/procedure or conditions for which it is prescribed.
- I understand that trained, non-medical school personnel shall administer medication/procedure.
- For Middle/High School students - my student has been instructed, is capable of self-administration, and has my consent to self-carry EPINEPHRINE:
  - ☐ Yes ☐ No **(REQUIRES practitioner signature and authorization below before valid.)**
- My signature indicates that I have fully read and understand the above information.

Parent/Guardian Signature: _____ Date: _____ Phone #: _____

PHYSICIAN AUTHORIZATION

The physician whose signature follows hereby authorizes school personnel to administer medication/procedure during the school day as prescribed. I agree to accept communication regarding the student/medication/procedure and understand trained, non-medical school personnel will administer the medication/procedure.

Epi Pen: This student has been instructed and is capable of self-administration and may self-carry Epi Pen: ☐ Yes ☐ No

Name of Physician: _____ Physician's Phone #: _____

Clinic Name and Address: _____

Physician's Signature: _____ Date: _____

Reviewed by: _____ Date: _____