Known Allergies:
_____
_____
_____
_____

Student Allergy Action Plan 2018-2019

(To be completed and signed by physician)

Student Photo Here

Student Name: _____ Grade: _____ Date of Birth: _____

STEP 1: TREATMENT

Asthmatic: ☐ Yes* ☐ No * Higher risk for severe reaction

Symptoms:	**Give Checked Medication**:** (**To be determined by physician authorizing treatment)	
If a student has come in contact with allergen, 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, blueness	☐ Epinephrine	☐ Antihistamine
Other** - _____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affect), give	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. **Potentially life threatening.

Dosage:

Epinephrine: inject intramuscularly (check one) ☐ Epi Pen ☐ Epi Pen Jr. ☐ Twinject 0.3mg ☐ Twinject 0.15mg

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____.
3. Emergency Contacts:

Name/Relationship	Phone numbers
a) _____	1. _____ 2. _____
b) _____	1. _____ 2. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

_____

Physician's Signature ***Date of Examination***

_____

Parent's Signature ***Date***

THE CALVERTON SCHOOL

Physician Medication Order Form [PMOF]

Known Drug Allergies:

Medication Administration Release and Authorization Form

Parental Waiver of Liability - Physician Request to Administer Medication During School Hours

NOTE: Use a separate form for each medication order. The Calverton School, without the written authorization of the parent and physician, cannot administer medication, prescribed or over the counter. This form must be kept current. The parent is responsible for providing all information needed for the proper administration of medication. A confirmation of current medications, which must be administered during school hours, must be made or renewed at the beginning of each school year. **Whenever there is a change in medication, the parents must have a new form completed by the physician.**

Student Name: _____ Grade: _____ Date of Birth: _____

To be completed by physician:

Medical Diagnosis of above named student: _____

The following medication is given during school hours: Medication Name _____

Route of Administration_____ Time of Administration _____

Dosage _____ Duration _____

FOR INHALER AND EPI-PEN MEDICATION ONLY (for students in Grades 6 to 12):

_____ **is able to self-administer** and carry inhaler medication or Epi-pen.
_____ **is trained in use** of inhaler and/or Epi-pen and knows when the medication is to be used.
_____ **should not self-administer** inhalant medication or Epi-pen.

I hereby consent and authorize the school Nurse and medication assistants of The Calverton School to administer the aforementioned medication to _____.

Physician's Name (Print Clearly) _____

Physician's Signature _____ Telephone Number _____

School Nurse/Med Tech and/or Residential House Parent may administer the following over-the-counter medications:

Put a check mark beside the following medications that may be administered on an as-needed basis. All **medications must be given directly to the Nurse in their original unopened package. All medications are given per package dosage instructions. All dosages given per package instructions, unless otherwise noted.**

____ Cough Drops ____Ibuprofen – dose _____ ____Tylenol – dose _____ ____ Tums _____Orajel
____ Topical Neosporin ____Topical Hydrocortisone ____Benadryl – dose _____ ____ Other _____

The parent must bring this completed form to The Calverton School, along with a continuing supply of medication in the original pharmacy container. A student must not transport medications. By signing below, the parent understands the possible consequences in the administration of the aforementioned medication. In consideration of administering said medication, the parent hereby releases, waives, discharges and hold harmless The Calverton School, its officers, director, and employees from any claims, demands, or suits for damages from any injury or complication which may result from the administration of the aforementioned medication.

Parent/Guardian Signature _____ Date _____

Relationship to Student_____ Daytime Phone Number _____

Person to contact in case of emergency if parent/guardian cannot be reached: _____

Please return this form to the Nurse:

The Calverton School, 300 Calverton School Road, Huntingtown, Maryland 20639 FAX: 410.535.6169