Valid for School Year
_____ to _____
Epinephrine
Auto Injector _____
Expiration date
Antihistamine _____
Expiration date

POWAY UNIFIED SCHOOL DISTRICT
15250 Avenue of Science, San Diego CA 92128

Place Student's Picture Here

LIFE THREATENING ALLERGY PLAN

STUDENT NAME_____ **BIRTHDATE**_____ **GRADE** _____

SCHOOL_____ **ALLERGY**_____

All Staff: Students with food allergies should not be given food unless it is provided or approved by parents. Parents may provide a container of safe treats for storage at school. It is advisable to limit the number of food events in your classroom. Classroom projects/crafts should be free of allergens. Children should be encouraged to wash hands before and after eating. Desks and surfaces should be wiped after food events in the classroom. Food should not be used as a reward. If there is a suspected exposure incident, contact the Health Technician and observe carefully. Reactions can be delayed! The severity of symptoms can quickly change.

Physician:
Please provide the following specific instructions to assist our Health Technician (or school staff) in providing emergency care as needed during school hours. Although our credentialed school nurses are not at the school, indirect supervision will be provided from the central office. 911 will be called when epinephrine is administered.

TREATMENT:

Symptoms:	**Give Checked Medication**	
• If an exposure incident has occurred, but no symptoms ……...……....	☐ Epinephrine	☐ Antihistamine
• Eyes: Itching, watery, swelling.....	☐ Epinephrine	☐ Antihistamine
• Mouth - Itching, tingling, 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 skin	☐ Epinephrine	☐ Antihistamine
• For 2 or more of the above systems, or progressive reaction	☐ Epinephrine	☐ Antihistamine

HISTORY OF ANAPHYLAXIS? Yes ☐ No ☐

Dosage:

Epinephrine: Inject intramuscularly ☐ Adult – 0.3 mg. ☐ Junior/Child – 0.15 mg.

After administering the epinephrine, monitor student closely until Emergency Medical Services arrive. Improvement in allergic symptoms should be seen within 5 minutes. If severe symptoms persist, or worsen, or improve but then start to return, a second dose of epinephrine should be administered in 5 - 10 minutes. ☐

Antihistamine: _____ dose: _____ mg.

Other: _____ dose: _____ (e.g. Albuterol)

If antihistamine is administered, student will be sent home.

➢ **PHYSICIAN'S SIGNATURE:** _____ **Date** _____

Phone_____ **Fax**_____ **CA Med. License #**_____

***I have read and accept conditions set forth by PUSD for treatment of Anaphylaxis (see page 2) and Parent Responsibilities in the PUSD Life Threatening Allergy Guidelines (attached).**

➢ **PARENT SIGNATURE:** _____**Phone**_____ **Date:** _____

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PARENT AUTHORIZATION FOR SPECIALIZED PHYSICAL HEALTH CARE SERVICE

I understand that only personnel meeting the requirements of California Education and Administration Codes will be performing the above mentioned health care service and will be using only the standardized procedure approved by our physician.

I will provide the medicine(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician *and* a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement.

I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

To facilitate the foregoing, I hereby grant permission for the exchange between our physician and the Poway Unified School District of that confidential medical information contained in my child's records necessary to accomplish this service.

I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change in or cancellation of the procedure.