ACTION PLAN FOR ANAPHYLAXIS

Patient’s Name: ____________________________
Date of Birth: ____________________________
Expiration Date for Medication Plan: ________

Health Care Provider: _________________________
Provider’s Phone Number: ______________________

Responsible Person (i.e., parent/guardian): _________________________
Phone Number: ____________________________

Emergency Contacts

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Patient’s known allergies:

WATCH FOR SIGNS AND SYMPTOMS OF ANAPHYLAXIS

Medication:
To prevent anaphylaxis shock administer a one-time injection in thigh or specify other location.

☐ EpiPen Jr. (0.15 mg)
☐ EpiPen (0.3 mg)
☐ Other ______________________

Only a few signs and symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life threatening:

- Rash (especially hives) with redness and swelling (especially on face, lips and tongue)
- Shortness of breath, cough, wheeze
- Difficulty talking and/or hoarse voice
- Abdominal pain, vomiting, diarrhea
- Loss of consciousness

ACT QUICKLY !!!!!

1. Stay with the child and have someone call 911.
2. Locate EpiPen (epinephrine).
3. Oversee or assist child in injecting the epinephrine in thigh using medication listed above.
4. Contact responsible person or other emergency contacts listed above.

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN AND YOUTH:

Healthcare Provider’s Initials
__________________________________________
This student was trained and is capable to self-administer with the auto injectable epinephrine pen.
__________________________________________
This student is not approved to self-medicate.

Health Care Provider’s Signature: _________________________
Date: __________________

As the Responsible Person, I hereby authorize a trained school employee to administer medication to the student.

As the Responsible Person, I hereby authorize this student to possess and self-administer medication.

As the Responsible Person I understand this student is not authorized to self-administer medication.

As the Responsible Person, I agree that the school and its employees and its agents shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

Responsible Person’s Signature: _________________________
Date: __________________

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FEBRUARY 2008
PATIENT COPY
DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
SCHOOL HEALTH PROGRAM
STUDENT HEALTH AUTHORIZATION FORMS

Name of Student: ______________________ Date of Birth: ______________________
School: ______________________ Social Security #: ______________________
Grade: ______________________

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this form.

I hereby request and authorize the school nurse/licensed practical nurse/certified DCPS personnel
to administer prescribed medications as directed by the physician to my son/daughter.

Student’s Name

I have received and read a copy of the procedures for medication authorization and agree to assume
responsibilities as required. This medication is a ____________ new or ____________ renewed
prescription. If this is a new prescription, enter the date and time of first dose given at home.

Date: ____________ Time: ____________ A.M. ____________ P.M. ____________

Name of Parent/Guardian: ______________________ Date: ____________

Please Print

_________________________ Signature of Parent/Guardian

_________________________ Relationship

Please take this form to the student’s physician for completion

PART II: PHYSICIAN’S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this medication authorization order.

Please check one: _____ Original _____ Renewal _____ Change

Name of Student: ______________________ Date of Birth: ______________________

Diagnosis: ______________________ Telephone #: ______________________

Name of Medication: ______________________

Dose: ______________________

Time and circumstances of administration at school: ______________________

Expected duration of administration: ______________________

Can reaction be expected? _____ Yes _____ No If yes, please describe: ______________________

_________________________ Physician’s Name:

_________________________ Physician’s Address:

_________________________ Telephone Number:

_________________________ Physician’s Date:

_________________________ Signature: ______________________

_________________________ School Nurse

_________________________ DCPS Qualified Staff

DC Public Schools
ACTION PLAN FOR ANAPHYLAXIS

Patient's Name                  Date of Birth                  Expiration Date for Medication Plan

Health Care Provider                  Provider’s Phone Number

Responsible Person (i.e., parent/guardian)                  Phone Number

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| Responsible Person’s Signature | Date |

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Government of the District of Columbia
Adrian M. Fenty, Mayor

FEBRUARY 2008

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