Allergic Reaction
Emergency Health Care Plan

ALLERGY TO:_____

Student's Name:_____D.O.B._____

Teacher:_____ Classroom: _____
Is child asthmatic? Yes _____ No _____

Signs of an Allergic Reaction Include (Circle student's usual symptoms):

MOUTH: itching and swelling of the lips, tongue or mouth
THROAT: itching and/or a sense of tightness in the throat, hoarseness and hacking cough
SKIN: hives, itchy rash and/or swelling about the face or extremities
GI TRACT: (uncommonly) nausea, abdominal cramps, vomiting and/or diarrhea
LUNGS: shortness of breath, repetitive coughing and/or wheezing
HEART: weak and "thready" pulse, "passing out"

The severity of symptoms can change quickly. All of the above symptoms can potentially progress to a life-threatening situation.

ACTION:

1. If ingestion, exposure or sting is suspected, give _____
(medication, dose, route)
and _____immediately.
(other actions to be taken)
2. Call 911 or local Emergency Medical Services.
3. Call: Mother/Guardian:ph# _____ Father:ph# _____
Pgr/cell# _____Pgr/cell # _____
Other emergency contacts_____
4. Or call Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED.

_____ _____
Parent/Guardian Signature Date

_____ _____
Healthcare Provider's Signature Date

Staff members trained to give Epipen® (name and room number)

1. _____ 2. _____

3. _____ 4._____

Written Authorization for Self-Administration of Epi-Pen Medication
by Minor Children at School

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

I, _____, Parent/Legal Guardian of the above-named student, hereby request authorization for self-administration and possession of Epi-Pen medication by this student while in school, at a school- sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her Epi-Pen.

I understand that:

- LCA and its employees and Board of Directors shall incur no liability for: a) any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her Epi-Pen medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty Epi-Pen medication and Epi-Pen devices;
- the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with Epi-Pen medication;
- the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of Epi-Pen medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of Epi-Pen medication, medication use, and refilling of prescriptions for Epi-Pen medication, as the school will not be responsible for the supervising, recording, and monitoring of self-administered Epi-Pen medication;
- ensuring the student always carries his/her Epi-Pen medication on his/her person;
- providing the school with the back-up medication;
- informing school staff **in writing** of any changes in the student's treatment or Epi-Pen management;
- informing the school of any Epi-Pen exacerbations, hospital visits, and/or new or changed student medical information;
- informing school staff **in writing** of any medication side effects that warrant communication to the parent/guardian;
- coordinating distribution of the student's Epi-Pen management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus driver, before-school and after-school staff).

I understand and agree to the conditions of the school policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release Loganville Christian Academy and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his or her Epi-Pen medication.

_____ _____
Parent/Legal Guardian Signature Date

I, _____, the above-named student, have been instructed in the proper use of my prescription asthma medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____ _____
Student's Signature Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her Epi-Pen medication. It is my professional opinion that the student should be permitted to carry and self-administer his/her Epi-Pen medication. I have provided the parent/guardian with a written emergency/management plan including the name, purpose, dosage, and administration directions of the Epi-Pen medication.

_____ _____
Physician's Signature Date