

# Physician Order/Severe Allergy Action Plan

Place Child's  
Picture Here

Student's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Grade: \_\_\_\_\_

## ALLERGIC

TO: \_\_\_\_\_

Asthmatic Yes\*  No  \*Higher risk for severe reaction

## STEP 1: TREATMENT (This section to be completed by authorizing physician)

### Symptoms:

- If exposure to allergen (e.g., sting, food ingested), but has no symptoms  Epinephrine  Antihistamine

### Give Checked Medications

### MILD SYMPTOMS

- Mouth Itchy runny nose, sneezing  Epinephrine  Antihistamine
- Skin A few hives, mild itch  Epinephrine  Antihistamine
- Gut Mild nausea/discomfort  Epinephrine  Antihistamine

### SEVERE SYMPTOMS - Potentially Life-Threatening

- Throat Tightening of throat, hoarseness, hacking cough
- Lung Shortness of breath, repetitive coughing, wheezing
- Heart Weak pulse, faint, pale, blue, dizzy
- Gut Repetitive vomiting, severe diarrhea
- Skin Many hives over body, widespread redness
- Other \_\_\_\_\_



**INJECT  
EPINEPHRINE  
IMMEDIATELY**

The severity of symptoms can quickly change. When both Epinephrine and Antihistamine are checked, **Epinephrine will be given first.** Antihistamine or other med given only if student alert and able to swallow.

### DOSAGE

**Epinephrine:** Inject intramuscularly (**check one**)  Epinephrine 0.15mg  Epinephrine 0.3 mg

**Antihistamine:** give \_\_\_\_\_ **Other:** give \_\_\_\_\_  
Medication/dose/route Medication/dose/route

**Physician's Signature** \_\_\_\_\_ **Start Date:** \_\_\_\_\_ **\*End Date:** \_\_\_\_\_  
(Required)

Physician's name (printed) \_\_\_\_\_ Phone \_\_\_\_\_ Fax number \_\_\_\_\_

**This student is both capable and responsible to self-administer the Epinephrine. This student may carry his/her Epinephrine:**

Physician's Signature and Date	Parent Signature and Date	Student's Signature and Date
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FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

\_\_\_\_\_  
SHA Signature and Date Name of PHN Contacted by Phone & Date PHN Signature and Date  
Please note: This form replaces the *Health Alert, Severe Allergy* form and the use of *Authorization for Medication* for severe allergy medication orders only.  
Revised 6/15

TURN FORM OVER

Students with conditions that may substantially impact school functioning (including medical or psychological conditions) may be eligible for accommodations under federal laws, specifically Section 504 of the Rehabilitation Act. Students or parents who are concerned that a diagnosed condition may interfere with the student's ability to access or participate in school activities should discuss their concerns with a school administrator.

## STEP 2: EMERGENCY CALLS (To be completed by parent/guardian)

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Call Parent/Guardian or Emergency contact(s):

Name/Relationship	Phone Number(s)
a. _____	1. _____ 2. _____
b. _____	1. _____ 2. _____
c. _____	1. _____ 2. _____

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

*I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel, including unlicensed persons, to give the medication described above as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools, Arlington Department of Human Services, Arlington County, and any of its officers, staff members, or agents from any lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student by administration of this medication to him/her as requested by the parents, including any adverse effects to the medication.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Order form good for one school year including Summer School.

Medication expiration dates: \_\_\_\_\_

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

\_\_\_\_\_  
SHA Signature and Date

\_\_\_\_\_  
Name of PHN Contacted by Phone & Date

\_\_\_\_\_  
PHN Signature and Date

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Revised 6/15

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## Orden Médica/Plan de Acción Para Alergias Severas

FOTO DEL NINO AQUI

NOMBRE DEL ESTUDIANTE: \_\_\_\_\_ FECHA de NAC: \_\_\_\_\_ Grado: \_\_\_\_\_

ALERGIA A: \_\_\_\_\_

Asmático SI\*  No  \*Riesgo de reacciones severas

### STEP 1: TREATMENT (This section to be completed by authorizing physician)

#### Symptoms:

#### Give Checked Medications

- |   |                                      |  |
|---|--------------------------------------|--|
| • If exposure to allergen (e.g., sting, food ingested), but has no symptoms | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Mouth Itching, tingling, or swelling of lips, tongue, mouth               | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Skin Hives, itchy rash, swelling of the face or extremities               | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Gut Nausea, abdominal cramps, vomiting, diarrhea                          | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Throat ❖ Tightening of throat, hoarseness, hacking cough                  | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Lung ❖ Shortness of breath, repetitive coughing, wheezing                 | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Heart ❖ Thready pulse, low blood pressure, fainting, pale, blueness       | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Other ❖ _____   | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • If reaction is progressing (several of the above areas affected), give    | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. ❖ Potentially life-threatening. When both EpiPen and Antihistamine are checked, **Epinephrine will be given first**. Antihistamine or other med given only if student alert and able to swallow.

#### DOSAGE

**Epinephrine:** Inject intramuscularly (**check one**)  Epinephrine  Epinephrine Jr. (See reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_ **Other:** give \_\_\_\_\_  
Medication/dose/route Medication/dose/route

**Physician's Signature** \_\_\_\_\_ **Start Date:** \_\_\_\_\_ **\*End Date:** \_\_\_\_\_  
(Required)

Physician's name (printed) \_\_\_\_\_ Phone \_\_\_\_\_ Fax number \_\_\_\_\_

This student is both capable and responsible to self-administer the Epinephrine / Este estudiante es capaz y responsable de administrarse a sí mismo el Epinefrina. This student may carry his/her Epinephrine / Este estudiante puede llevar consigo la Epinefrina:

Physician's Signature and Date \_\_\_\_\_

Firma y Fecha del Padre/Guardian \_\_\_\_\_

Student's Signature and Date \_\_\_\_\_

### • STEP 2: EMERGENCY CALLS (Completado por el Padre/Tutor) •

1. Llamar: **911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Llamar al Padre/Guardián ó Contacto(s) de Emergencia  
**Nombre/Relación** **Teléfono(s)**

a. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_  
b. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_  
c. \_\_\_\_\_ 1. \_\_\_\_\_ 2. \_\_\_\_\_

**AUNQUE NO PUEDA LOCALIZAR AL PADRE/GUARDIAN,**

FOR STAFF ONLY: Signing here indicates that the medication review has been completed.

SHA Signature and Date \_\_\_\_\_

Name of PHN Contacted by Phone & Date \_\_\_\_\_

PHN Signature and Date \_\_\_\_\_

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**NO VACILE EN DAR EL MEDICAMENTO O LLEVAR AL ESTUDIANTE AL HOSPITAL!**

Por la presente autorizo al personal del Departamento de Servicios Humanos y de las Escuelas Públicas del Condado de Arlington incluyendo personal no licenciado, a dar medicinas de la forma indicada en esta autorización. Yo estoy de acuerdo en liberar, indemnizar y dejar sin responsabilidad a las Escuelas Públicas, el Departamento de Servicios Humanos, al Condado de Arlington y cualquiera de sus oficiales, miembros del personal, o agentes, en un juicio legal, reclamo, gasto, demanda o acción, etc., contra ellos por ayudar a este estudiante con la administración de medicamentos solicitado por los padres, incluyendo cualquier efecto secundario de la medicina.

**Firma del Padre/Guardián** \_\_\_\_\_ **Fecha** \_\_\_\_\_

\* Orden válida por un año escolar incluyendo la escuela de verano. **Fecha de Expiración de los medicamentos:** \_\_\_\_\_

**• STEP 2: EMERGENCY CALLS (To be completed by parent/guardian) •**

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Call **Parent/Guardian** or Emergency contact(s):

	<b>Name/Relationship</b>	<b>Phone Number(s)</b>
a.	_____	1. _____ 2. _____
b.	_____	1. _____ 2. _____
c.	_____	1. _____ 2. _____

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**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*Order form good for one school year including Summer School. **Medication expiration dates:** \_\_\_\_\_

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SHA Signature and Date

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Name of PHN Contacted by Phone & Date

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PHN Signature and Date

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