Student Name _____ Attachement B

Oxford Community Schools
SEVERE ALLERGY Medical Action Plan (MAP)

Child's picture

Student's Name _____
Date of birth _____ **School** _____
Age _____ **Grade**_____ **School Year**_____

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medications.

Transportation Office Use ONLY if needed
Bus # Driver:
Route # Medical File

CONTACT INFORMATION

		Call First	Try Second
Parent/ Guardian:	Name:	_____	_____
	Relationship:	_____	_____
Phone:	Home:	_____	_____
	Cell:	_____	_____
	Work:	_____	_____

Call Third (If a parent/guardian cannot be reached)
Name: _____ Relationship: _____
Address: _____ Phone: _____

ALLERGIC HISTORY

Has your child ever been given an epinephrine shot for an allergic reaction? **YES** **NO**

Does your child have Asthma? (If yes, at a higher risk for severe allergic reaction) **YES** **NO**

If your child needs medication at school for asthma, please complete a separate ASTHMA Medical Action Plan

List all Allergic FOOD If nuts, please specify by circling one or both: Peanut Tree Nut

_____

I request that my child sit at a no nut food allergy friendly table for meals **YES** **NO**

List of Different SEVERE ALLERGIES (such as, Insect sting or Latex)

_____

List of other foods that should be avoided, but are not a risk for a severe allergic reaction

_____

If my child is to self-carry epinephrine, I will still supply the school office with a back up auto-injector. **YES** **NO**

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having severe allergy to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to give the medication(s) as ordered on page 2 of this MAP for allergic reactions and to contact the physician/licensed prescriber for clarification, if needed.

Date_____Parent/Guardian _____
Signature

If checked, **give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

If checked, **give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted**.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
Gut:	Vomiting, crampy pain

1. **Inject Epinephrine Immediately**
2. Call 911
3. Begin monitoring (See "Monitoring" box below)
4. Give additional medication*
   (If ordered)
   -Antihistamine
   -Inhaler

*Antihistamines & inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

Mouth:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **Give Antihistamine**
2. Stay with student; Call parent/guardian
3. If symptoms progress:
   USE EPINEPHRINE (above)
4. Begin monitoring (See below)

Monitoring

Stay with student; call 911and parent/guardian. Tell rescue squad epinephrine was given. Note time epinephrine was given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For severe reaction, consider keeping student lying on back with legs raised. Keep head to side if vomiting. Treat student even if parents cannot be reached.

See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Epinephrine dose **.15 (junior)** **.3 (adult)** Auto injector brand name if known _____
Two doses are to be made available at school **YES** **NO**

It is my professional opinion that student should self-carry epinephrine **YES** **NO**

NOTE: ***If a student is to self carry their epinephrine, help may still be needed to give the medication***.

Antihistamine name _____ **Dosage** (please do not give a range) _____

Other instructions or orders _____

Physician/licensed prescriber name _____

Phone number _____ **FAX number** _____

Signature _____ **Date** _____