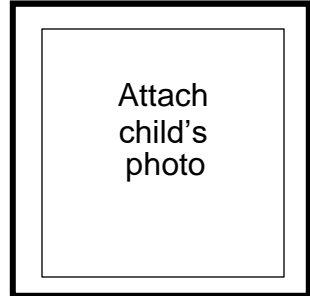




Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Weight: \_\_\_\_\_ School/Grade/: \_\_\_\_\_ BUS # \_\_\_\_\_

Child has allergy to \_\_\_\_\_



- Child has asthma.  Yes  No (If yes, higher chance severe reaction)  
 Child has had anaphylaxis.  Yes  No  
 Child may SELF carry medicine.  Yes  No  
 Child may give him/herself medicine.  Yes  No (If child refuses/is unable to self-treat, an adult must give medicine)

**IMPORTANT REMINDER**

**Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.**

**For Severe Allergy and Anaphylaxis  
 What to look for**



If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

**SPECIAL SITUATION:** If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): \_\_\_\_\_. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

**Give epinephrine!  
 What to do**

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
  - Ask for ambulance with epinephrine.
  - Tell rescue squad when epinephrine was given.
3. Stay with child and:
  - Call parents or emergency contact.
  - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
  - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
  - Antihistamine
  - Inhaler/bronchodilator

**For Mild Allergic Reaction  
 What to look for**



If child has had any mild symptoms, **monitor child.**

Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

**Monitor child  
 What to do**

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents or emergency contact.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

**Medicines/Doses**

Epinephrine, intramuscular (list type): \_\_\_\_\_ | 0.10 mg (7.5 kg to less than 13 kg)\*

0.15 mg (13 kg to less than 25 kg)

0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): \_\_\_\_\_ (\*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): \_\_\_\_\_

Parent/Guardian Authorization Signature

Date

Physician/HCP Authorization Signature

Date

Springboro Community City Schools Health Services  
**Allergy and Anaphylaxis Emergency Plan**



Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

**Additional Instructions: Pg 2 to be Completed by the Parent and Clinic Nurse**

I have read and understand Springboro Community City Schools Medication Policy. I give my permission for information to be sent to the school district via facsimile.

I, hereby, authorize designated personnel of the Springboro Community City School District to administer the above named medication or procedure as instructed by the physician, and agree to:

1. Provide the school with the medication in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
2. Notify the school if we change physicians.
3. Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.
4. Release authorized school employees from all liability, cause of action, or any other responsibility for administering said medicines as noted above.

Parent Signature: \_\_\_\_\_ Clinic Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Completed by Clinic Staff at Medication Check-In/Processing:**

Medication/Dosage: \_\_\_\_\_ Med Expiration Date: \_\_\_\_\_

Medication/Dosage: \_\_\_\_\_ Med Expiration Date: \_\_\_\_\_

Medication/Dosage: \_\_\_\_\_ Med Expiration Date: \_\_\_\_\_

DASL Entry: \_\_\_\_\_ Health Concern List: \_\_\_\_\_ EAP Copies Made/Distributed: \_\_\_\_\_ / \_\_\_\_\_

Medication Sign Out: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

School Activity Participation (\*Grades 7-12) BAND JROTC Athletics \_\_\_\_\_

Form Revision 5/2024

## Contacts

Clinic Nurse Name/ Phone #: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

### Other Emergency Contacts

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_