



Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_ Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

School Year/School: \_\_\_\_\_ Allergy free table at lunch: [ ] Yes [ ] No








**PLACE  
PICTURE  
HERE**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following foods:** \_\_\_\_\_  
THEREFORE:  
[ ] 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.

FOR ANY OF THE FOLLOWING:





## SEVERE SYMPTOMS

 <b>LUNG</b> Short of breath, wheezing, repetitive cough	 <b>HEART</b> Pale, blue, faint, weak pulse, dizzy	 <b>THROAT</b> Tight, hoarse, trouble breathing/swallowing	 <b>MOUTH</b> Significant swelling of the tongue and/or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	<b>OR A COMBINATION</b> of symptoms from different body areas.

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- INJECT EPINEPHRINE IMMEDIATELY.**
- Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

 <b>NOSE</b> Itchy/runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea/discomfort
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FOR **MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA**, GIVE EPINEPHRINE.

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FOR **MILD SYMPTOMS FROM A SINGLE SYSTEM AREA**, FOLLOW THE DIRECTIONS BELOW:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

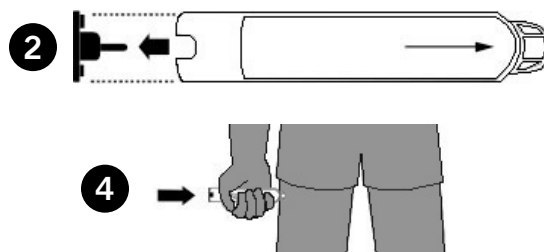
\_\_\_\_\_

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly. Please return to care plan to Health Services at Oconomowoc Area School District. Phone 262-560-2104 Fax 262-560-2106

Student Name: \_\_\_\_\_

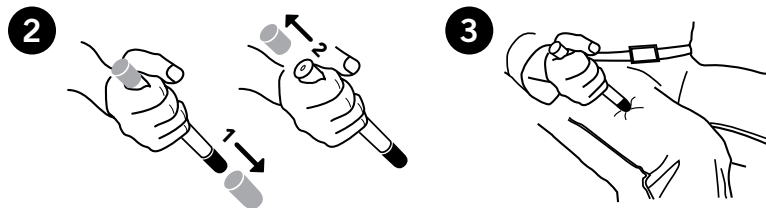
### EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



### ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



### OTHER DIRECTIONS/INFORMATION

Practitioner Name: \_\_\_\_\_

Practitioner Phone: \_\_\_\_\_

Practitioner Fax: \_\_\_\_\_

It is in my professional opinion that this student be allowed to carry his/her Epi-pen medication.

It is in my professional opinion that this student NOT be allowed to carry his/her Epi-pen medication.

How should medications be returned home at the end of the year:

Sent home with student

Parent/Guaradian Pick-up

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named practitioner (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

PRACTITIONER SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_