Allergy Action Plan

Student's Name:_________________________________ Date of Birth:_____________________________
School: ____ Teacher/ Grade: __________________________
Parent/ Guardian:____
Home Phone:______________________Work Phone: _______________Cell Phone:_______________________

Allergic to: ☐ Bee Sting ☐ Food (specify)____
☐Other (specify):____

☐ *****Medical documentation of food allergies is required to be submitted yearly*****

SIGNS OF ALLERGIC REACTION (check all that apply to your child):

☐ Itching ☐ Rash ☐ Swelling or redness at sting site
☐ Hives ☐ Nausea/ Vomiting ☐ Itching/ swelling lips, tongue, or mouth
☐ Other (specify) ______________________________ ☐ Trouble breathing, swallowing, talking

I would rate the severity of my child's allergy as: (please circle one)

Not severe 1 2 3 4 5 Severe

- JCSD Policy states that designated personnel may carry **emergency** meds on field trips.
- If your child must carry **emergency** meds at all times, please have the **"Release-To-Carry Form For Asthma Inhaler, Anaphylaxis Medication, and/ or Insulin Supplies"** form filled out.

TREATMENT (To Be Filled Out By Physician):

1. Administer_______________________________________Dose________________Route ________________

   if symptoms are: ____
2. Administer_______________________________________Dose________________Route ________________

   if symptoms are: ____
3. ***Call 911 if epinephrine aut- injector is given or if reaction is severe or if emergency meds not available.***
4. Call parents or emergency contacts.

Physician Signature: ____ Date ________________________
Required for **any** medications to be given at school

Parent Signature: ____ Date ________________________

Emergency Contacts:
1. Name____Phone Number ____________________
2. Name____Phone Number ____________________
3. Name____Phone Number ____________________

JONES COUNTY SCHOOL DISTRICT
RELEASE-TO-CARRY FORM FOR ASTHMA INHALER, ANAPHYLAXIS MEDICATION, AND/OR INSULIN SUPPLIES

Date:______________________________School: ____________________________________

____has been instructed in the proper use of
(student's name)

____Medication(s).
(name of medication(s)

Diagnosis #1: ____

Name of medication #1: ____

Dosage: ____

Diagnosis #2: ____

Name of medication #2: ____

Dosage: ____

We,_________________________and_____________________________, request that
(physician) (parent/guardian)

____
(student's full name)

be permitted to carry the asthma inhaler, anaphylaxis medication(s), and/or insulin supplies on his/her person, or to keep the asthma inhaler, anaphylaxis medication(s), and/or insulin supplies in his/her classroom or locker. He/she has been instructed in and understands the purpose, appropriate method, and frequency of use of his/her medication(s) as well as the proper method of disposal.

We, the undersigned physician and parent/guardian, absolve the school district and its employees, agents and officers of any responsibility in safeguarding our child's asthma inhaler, anaphylaxis medication(s), and/or insulin supplies.

We understand that the school district and its employees and agents will not be held liable for any injury sustained by the student that has self-administered emergency medication(s).

_________________________________ (Physician's signature)

_________________________________ (Parent/Legal guardian signature)

_________________________________ (Principal's signature)

_________________________________ (School Nurse's signature)

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