ACTION PLAN FOR ANAPHYLAXIS

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
<th>Expiration Date for Medication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider</td>
<td>Provider’s Phone Number</td>
<td></td>
</tr>
<tr>
<td>Responsible Person (i.e., parent/guardian)</td>
<td>Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contacts</th>
<th>Home Telephone Number</th>
<th>Work Number</th>
<th>Cellular Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient’s known allergies:

WATCH FOR SIGNS AND SYMPTOMS OF ANAPHYLAXIS

Medication:
To prevent anaphylaxis shock administer a one-time injection in thigh or specify other location.

Only a few signs and symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life threatening:

- Rash (especially hives) with redness and swelling (especially on face, lips and tongue)
- Shortness of breath, cough, wheeze
- Difficulty talking and/or hoarse voice
- Abdominal pain, vomiting, diarrhea
- Loss of consciousness

ACT QUICKLY !!!!!!

1. Stay with the child and have someone call 911.
2. Locate EpiPen (epinephrine).
3. Oversee or assist child in injecting the epinephrine in thigh using medication listed above.
4. Contact responsible person or other emergency contacts listed above.

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN AND YOUTH:

<table>
<thead>
<tr>
<th>Healthcare Provider’s Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Provider’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________________</td>
<td></td>
</tr>
</tbody>
</table>

This publication was supported by Cooperative Agreement Number U59/CCU324208-03 from the Centers for Disease Control and Prevention (CDC). Its content is solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Permission to Reproduce Blank Form
DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
SCHOOL HEALTH PROGRAM
STUDENT HEALTH AUTHORIZATION FORMS

Name of Student: ___________________________ Date of Birth: ___________________________
School: ___________________________ Social Security #: ___________________________
Grade: ___________________________

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this form.

I hereby request and authorize the school nurse/licensed practical nurse/certified DCPS personnel
to administer prescribed medications as directed by the physician to my son/daughter.

_________________________________________  ___________________________
Student’s Name  Date

I have received and read a copy of the procedures for medication authorization and agree to assume
responsibilities as required. This medication is a _______ new or _______ renewed
prescription. If this is a new prescription, enter the date and time of first dose given at home.

Date: ___________________________ Time: _________ _________ A.M. _________ P.M. _________

Name of Parent/Guardian: ___________________________  ___________________________  Date: ___________________________

Please Print

_________________________________________  ___________________________
Signature of Parent/Guardian  Relationship

Please take this form to the student’s physician for completion

PART II: PHYSICIAN’S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this medication authorization order.

Please check one: _______ Original  _______ Renewal  _______ Change

Name of Student: ___________________________ Date of Birth: ___________________________
Diagnosis: ___________________________ Telephone #: ___________________________
Name of Medication: ___________________________
Dose: ___________________________

Time and circumstances of administration at school: ___________________________
Expected duration of administration: ___________________________
Can reaction be expected? ______ Yes ______ No  If yes, please describe: ___________________________

______________________________  ___________________________
Physician’s Name  ___________________________
Physician’s Address: ___________________________
Telephone Number: ___________________________

______________________________  ___________________________
Physician’s Signature  Date

_________________________________________  DCPS Qualified Staff
School Nurse  DCPS Qualified Staff

DC Public Schools
# ACTION PLAN FOR ANAPHYLAXIS

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
<th>Expiration Date for Medication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Provider</th>
<th>Provider’s Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsible Person (i.e., parent/guardian)</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contacts</th>
<th>Home Telephone Number</th>
<th>Work Number</th>
<th>Cellular Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s known allergies:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## WATCH FOR SIGNS AND SYMPTOMS OF ANAPHYLAXIS

### Medication:

To prevent anaphylaxis shock administer a one-time injection in thigh or specify other location.

- [] EpiPen Jr. (0.15 mg)
- [] EpiPen (0.3 mg)
- [] Other ____________________

Only a few signs and symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life threatening:

- Rash (especially hives) with redness and swelling (especially on face, lips and tongue)
- Shortness of breath, cough, wheeze
- Difficulty talking and/or hoarse voice
- Abdominal pain, vomiting, diarrhea
- Loss of consciousness

### ACT QUICKLY !!!!!!

1. Stay with the child and have someone call 911.
2. Locate EpiPen (epinephrine).
3. Oversee or assist child in injecting the epinephrine in thigh using medication listed above.
4. Contact responsible person or other emergency contacts listed above.

## SCHOOL MEDICATION CONSENT AND PROVIDER’S ORDER FOR CHILDREN AND YOUTH:

<table>
<thead>
<tr>
<th>Healthcare Provider’s Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

This student was trained and is capable to self-administer with the auto injectable epinephrine pen.

<table>
<thead>
<tr>
<th>Healthcare Provider’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This student is not approved to self-medicate.

- [ ] As the Responsible Person, I hereby authorize a trained school employee to administer medication to the student.
- [ ] As the Responsible Person, I hereby authorize this student to possess and self-administer medication.
- [ ] As the Responsible Person, I understand this student is not authorized to self-administer medication.

As the Responsible Person, I agree that the school and its employees and its agents shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

<table>
<thead>
<tr>
<th>Responsible Person’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**ACTION PLAN FOR ANAPHYLAXIS**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
<th>Expiration Date for Medication Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health Care Provider</th>
<th>Provider’s Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Responsible Person (i.e., parent/guardian)</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Emergency Contacts</th>
<th>Home Telephone Number</th>
<th>Work Number</th>
<th>Cellular Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient’s known allergies:**

**WATCH FOR SIGNS AND SYMPTOMS OF ANAPHYLAXIS**

**Medication:**

To prevent anaphylaxis shock administer a one-time injection in thigh or specify other location.

- EpiPen Jr. (0.15 mg)
- EpiPen (0.3 mg)
- Other ____________________

Only a few signs and symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life threatening:

- Rash (especially hives) with redness and swelling (especially on face, lips and tongue)
- Shortness of breath, cough, wheeze
- Difficulty talking and/or hoarse voice
- Abdominal pain, vomiting, diarrhea
- Loss of consciousness

**ACT QUICKLY !!!!!**

1. Stay with the child and have someone call 911.
2. Locate EpiPen (epinephrine).
3. Oversee or assist child in injecting the epinephrine in thigh using medication listed above.
4. Contact responsible person or other emergency contacts listed above.

**SCHOOL MEDICATION CONSENT AND PROVIDER’S ORDER FOR CHILDREN AND YOUTH:**

**Healthcare Provider’s Initials**

- This student was trained and is capable to self-administer with the auto injectable epinephrine pen.
- This student is not approved to self-medicate.

**Health Care Provider’s Signature**

As the Responsible Person, I hereby authorize a trained school employee to administer medication to the student.

As the Responsible Person, I hereby authorize this student to possess and self-administer medication.

As the Responsible Person I understand this student is not authorized to self-administer medication.

As the Responsible Person, I agree that the school and its employees and its agents shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

**Responsible Person’s Signature**

This publication was supported by Cooperative Agreement Number U59/CCU324208-03 from the Centers for Disease Control and Prevention (CDC). Its content is solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Permission to Reproduce Blank Form

**DOH**

**Government of the District of Columbia**

Adrian M. Fenty, Mayor