School District of Manawa
"Students Choosing to Excel, Realizing Their Strengths"
800 Beech Street | Manawa, WI 54949 | (920) 596-2525
District Fax (920) 596-5308 | Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

ALLERGY - ANAPHYLAXIS MANAGAEMENT PLAN

School Year ______________

Student ______________________ Birth Date ___/___/___ Age ____ Grade ____

School Attending:
- ☐ Elementary School • Phone (920) 596-5700 • Fax (920) 596-5339 Teacher/Advisor ______________
- ☐ Little Wolf Middle/High School • Phone (920) 596-5800 • Fax (920) 596-2655 Teacher/Advisor ______________

Allergies ______________________ Asthma ☐ No ☐ Yes (higher risk for severe reaction)

Describe known symptoms from previous insect stings, food ingestion, or reaction to non-food items:

____

STUDENT IS EXTREMELY REACTIVE ☐ No ☐ Yes, list: ______________________

Administer EPI. Call 911 immediately for ANY SYMPTOMS if:

☐ Allergen was LIKELY eaten, or student came into contact with the allergen.

☐ Allergen was DEFINITELY eaten or came into contact with the allergen EVEN IF NO SYMPTOMS ARE NOTED.

MEDICATION TO BE GIVEN AT SCHOOL		Dosage	Route	As Needed	Daily / Time	Reason/Symptoms
☐ Antihistamine	Name			☐	☐	
☐ EpiPen	☐ 0.15 mg ☐ 0.3 mg			☐	☐	
☐ Other	Name			☐	☐	

PARENT • GUARDIAN • EMERGENCY CONTACT

Parent / Guardian 1	Name ______	Relationship ______	Phone ( ) -
	Workplace ______		Work Phone ( ) -
Parent / Guardian 2	Name ______	Relationship ______	Phone ( ) -
	Workplace ______		Work Phone ( ) -
Emergency Contact 3	Name ______	Relationship ______	Phone ( ) -
	Workplace ______		Work Phone ( ) -

CONSENT FOR MANAGEMENT OF HEALTH CONDITION AT SCHOOL OR SCHOOL-SPONSORED ACTIVITIES

I, the parent/legal guardian, of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Further, I agree to:

1. Provide necessary supplies & equipment in original pharmacy labelled container and/or manufacturer's packaging and within the expiration date.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify school staff or school district nurse; complete new forms for any changes in the student's health status, orders from the student's health care provider, etc.
4. Ensure this form is signed by the appropriate medical provider who manages the medical condition, prescription and/or in doses that exceed the manufacturer's recommended dosages for non-prescription medications or over-the-counter (OTC) medications.
5. Authorize designated school staff or school nurse to communicate directly with primary care provider or specialist regarding health condition & medication.
6. Authorize school staff interacting directly with my child to be informed about this health care plan.
7. Submit new forms annually if the health condition and/or need for medication still exists or inform the school that the condition no longer exists and provide documentation of such, if deemed necessary.
8. Hold without liability the School District of Manawa, its' Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Legal Guardian Signature ______________________ Date ______________

Student signature is required if student is 18 years old or attaining 18 years old during the school year

Student Signature ______________________ Date ______________

Student's Name: ______________________ School Year ______________

PHYSICIAN INFORMATION/SIGNATURE

Print Name ______________________ Phone ( )

Medical Facility ______________________ Fax ( )

Address ______________________ City, State, Zip ______________________

For students in 5th grade and up

☐ I have instructed the student in the proper way to use his/her medications. It is my opinion that he/she should be allowed to carry and administer inhaled medication by him/herself.

☐ It is my opinion that the student should not carry nor administer his/her inhaled medication by him/herself.

Physician Signature ______________________ Date ______________

SYSTEM AREA – MILD SYMPTOMS

- Nose — Itchy/runny nose, sneezing
- Mouth — Itching, tingling, or swelling of lips, tongue, mouth
- Skin — Hives, itchy rash, swelling of the face or extremities
- Stomach — Mild nausea, discomfort, cramping

ACTION

1. Student's antihistamine may be given if ordered by a medical provider.
2. Stay with student and monitor for changes.
3. If symptoms worsen or there are symptoms from more than one system area, follow severe symptoms action plan below.

SYSTEM AREA – SEVERE SYMPTOMS

Suspected or known food ingestion, sting or contact with allergen or any of the following. Severity of symptoms can quickly change.

- Lungs — Shortness of breath, wheezing, repetitive cough
- Heart — Faint/dizzy, weak pulse, pale or bluish skin
- Throat — Tightness, hoarse, trouble breathing/swallowing
- Mouth — Significant swelling of the tongue or lips
- Skin — Many hives over body, widespread redness
- Stomach — Severe diarrhea, repetitive vomiting

ACTION

1. Inject epinephrine immediately.
2. Call 911, advising student is in anaphylaxis.
3. Consider giving additional medications if included in this plan: antihistamine, other.
4. Lay person flat with legs elevated. If breathing is difficult or student is vomiting, allow them to sit up or lie on their side.
5. If symptoms don't improve or worsen after 5 minutes, give a second dose of epinephrine if available.
6. Alert parent/guardian or emergency contact.