



# ALLERGY/ANAPHYLAXIS EMERGENCY PLAN & MEDICATION AUTHORIZATION

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: 2025-2026

Grade: \_\_\_\_\_ School: WDHS \_\_\_\_\_ WDMS \_\_\_\_\_ SHE \_\_\_\_\_ LDE \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

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

ALLERGIC TO: \_\_\_\_\_ History of Asthma: ☐ YES ☐ NO

SEVERE SYMPTOMS		EMERGENCY PROCEDURE
LUNG	Short of Breath, wheezing, repetitive cough	<ol style="list-style-type: none"> <li>1. <b>INJECT EPINEPHRINE IMMEDIATELY</b> for ANY of the listed <b>SEVERE symptoms</b> (Note time given)</li> <li>2. <b>CALL 911.</b> Tell the emergency dispatcher that epinephrine was given.</li> <li>3. Give antihistamine, if ordered below.</li> <li>4. Given rescue inhaler, if ordered below.</li> <li>5. Lay the student flat and raise legs, keep warm. If student has difficulty breathing or is vomiting, let them sit up or lie on their side.</li> <li>6. After 5 minutes, if symptoms do not improve or worsen, give second dose of epinephrine..</li> <li>7. Alert emergency contacts (parent/guardian).</li> <li>8. If stung by insect, apply ice to the site.</li> </ol>
HEART	Pale, blue, faint, weak pulse, dizzy	
THROAT	Tight, hoarse, trouble breathing/swallowing	
MOUTH	Significant swelling of the tongue and/or lips	
SKIN	Many hives over body, widespread redness	
GUT	Repetitive vomiting or severe diarrhea	
OTHER	Feeling something bad is about to happen, anxiety, confusion *OR a combination of mild or severe symptoms from different body areas.	

  

MILD SYMPTOMS		PROCEDURE
NOSE	Itchy/runny nose, sneezing	<ol style="list-style-type: none"> <li>1. <b>GIVE ANTIHISTAMINES, IF ORDERED BELOW.</b></li> <li>2. Stay with student &amp; watch closely for changes.</li> <li>3. Alert emergency contacts. (parent/guardian)</li> <li>4. If stung by insect, apply ice to the site.</li> <li>5. If symptoms worsen or involve more than one body system area <b>GIVE EPINEPHRINE and CALL 911.</b></li> </ol>
MOUTH	Itchy mouth	
SKIN	A few hives, mild itch	
GUT	Mild nausea/discomfort	

## EMERGENCY MEDICATIONS:

<b>EPINEPHRINE</b>	<input type="checkbox"/> Epinephrine (0.15mg) inject intramuscularly (circle one) EpiPen Auvi Q Adrenaclick		<input type="checkbox"/> Epinephrine (0.3mg) inject intramuscularly (circle one) EpiPen Auvi Q Adrenaclick	
	A second dose of epinephrine can be given 5 minutes or more after the first dose if symptoms persist or recur			
<b>ANTI HISTAMINE</b> Do not depend on antihistamines or inhalers. When in doubt, give epinephrine & CALL 911.	<input type="checkbox"/> Benadryl/Diphenhydramine Dose: _____ mg Route: Oral		<input type="checkbox"/> Other Dose: _____ mg Route: _____	

## PARENT/GUARDIAN CONSENT: (Review each item before signing)

- I understand that all medication is to be delivered to the school and picked up from the school by parent/guardian/ responsible adult unless the healthcare provider below indicates that student may self carry, self-administer medication.
- I will supply medication in it's original, dated, properly labeled container. (request extra bottle from the pharmacy)
- I understand that this order is in effect for the current school year only, unless otherwise indicated.
- I request and authorize that school personnel administer this medication or perform this procedure at school.
- I will obtain a new Physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's healthcare provider regarding this medication/procedure or the conditions for which it is prescribed.
- I understand that non-medical, trained school personnel will be administering medications & performing procedures.
- I understand that I am responsible to assure that backup rescue medication is available to my child outside of school hours and traveling to/from and during school-sponsored events.
- I agree to hold the School District of Wisconsin Dells, 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/procedure at school.
- **For any age student: ASTHMA INHALERS & EPIPENS ONLY**  
This student is capable of self-administration & may carry an inhaler or EPIPEN & self-administer in school. ( ) YES ( ) NO
- My signature indicates that I have fully read and understand the above information.

Signature of Parent/Legal Guardian

Date

Phone Number

## PHYSICIAN ORDER:

The above medication/procedure is to be administered during the school day in accordance with the above instructions and agreements. I agree to exchange information verbally or in writing about the student/medication/procedure and understand that non-medical, trained school personnel will administer the medication/procedure.

**SELF CARRY, SELF ADMINISTER:** **For any age student: ASTHMA INHALERS & EPIPENS ONLY** This student and their parents/guardians have been instructed in self-administration and student may carry an inhaler or EPIPEN & self-administer in school. ( ) YES ( ) NO

Signature of Licensed Healthcare Provider

Date

Phone Number

Printed Name

Fax Number