

Cc:  
☐ Teacher (s)  
☐ PE Teacher  
Office use only

**DOWNEY UNIFIED SCHOOL DISTRICT**  
**ALLERGY CARE PLAN & MEDICATION AUTHORIZATION**

**School Year:** \_\_\_\_\_

**GRADE:** \_\_\_\_\_

**CHILD'S NAME** \_\_\_\_\_ **D.O.B** \_\_\_\_\_ **SCHOOL** \_\_\_\_\_

**PARENT NAME** \_\_\_\_\_ **PHONE (HOME)** \_\_\_\_\_ **(WORK)** \_\_\_\_\_

**ADDITIONAL EMERGENCY CONTACT: NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_

The above named pupil is required to take medication prescribed by a physician during the regular school day. I request that designated School District personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I authorize the District to communicate with the physician below regarding my child's medical condition and/or the medication prescribed for it. *If authorized by physician below, I consent to self-administration of \_\_\_\_\_ Asthma Inhaler \_\_\_\_\_ Epi-Pen and release the district and school personnel from civil liability in the event of an adverse reaction to the medication.*

**PARENT ACKNOWLEDGEMENT: I have read and acknowledge both front and back of this form.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Signature of Parent/Guardian

**PHYSICIAN TO COMPLETE**

**ALLERGY TO:** \_\_\_\_\_

**FACTORS THAT TRIGGER STUDENT'S ALLERGIC REACTION:** \_\_\_\_\_

**ASTHMATIC?** \_\_\_\_\_ YES (HIGH RISK FOR SEVERE REACTION) \_\_\_\_\_ NO

**ANAPHYLACTIC HISTORY** \_\_\_\_\_ YES \_\_\_\_\_ NO

IF REACTION IS SUSPECTED AT SCHOOL – GIVE:

**ACTION AND TREATMENT:**

| Name of Medication | Dosage | Dose Form (HFA, Nebulizer, Tab, Liquid, Etc.) | Time |
|--------------------|--------|-----------------------------------------------|------|
|                    |        |                                               |      |
|                    |        |                                               |      |

2. CALL PARAMEDICS

3. CALL PARENTS

4. **ADDITIONAL STEPS TO TAKE (IF ANY):** \_\_\_\_\_

- TRAINED SCHOOL PERSONNEL MAY ADMINISTER INJECTABLE EMERGENCY MEDICATION IN THE EVENT OF AN ANAPHYLACTIC REACTION.

**SIGNS OF AN ALLERGIC REACTION INCLUDE:**

**SYSTEMS:**

**SYMPTOMS:**

- MOUTH ITCHING AND SWELLING OF THE LIPS, TONGUE, OR MOUTH
- THROAT ITCHING AND/OR A SENSE OF TIGHTNESS IN THE THROAT, HOARSENESS, HACKING COUGH, DIFFICULTY SWALLOWING
- SKIN HIVES, ITCHY RASH, AND/OR SWELLING ABOUT THE FACE OR EXTREMITIES
- GUT NAUSEA, ABDOMINAL CRAMPS, VOMITING, AND/OR DIARRHEA
- LUNG SHORTNESS OF BREATH, REPETITIVE COUGHING, AND/OR WHEEZING
- HEART "THREADY" PULSE, "PASSING OUT"

**THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!**

**DO NOT HESITATE TO ADMINISTER MEDICATION AND/OR CALL PARAMEDICS - EVEN IF PARENT/GUARDIAN CANNOT BE REACHED!**

The pupil named above for whom this medication is prescribed, is under my care.

\_\_\_\_\_  
Print Name of Physician

\_\_\_\_\_  
Signature of Physician - REQUIRED

\_\_\_\_\_  
Office Stamp - REQUIRED

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

Physician: Please check if applicable: I verify this student has demonstrated knowledge of correct dosage and usage of: ☐ Asthma inhaler and/or ☐ Epinephrine Pen and as the prescribing physician I request the student to carry this medication on his/her person while at school.

**FIRST AID FOR SEVERE ALLERGY ON REVERSE SIDE**

Medication Regulations on reverse side

## **FIRST AID FOR ANAPHYLACTIC REACTIONS (SEVERE ALLERGIC REACTIONS)**

Anaphylaxis (anaphylactic shock) is a very serious and acute allergic reaction of the body to overwhelming sensitization by a foreign protein. It may be produced when a susceptible person is, for example, stung by a bee, has eaten particular foods or taken certain medications or drugs. The victim may become weak, pale and collapse. He/she has great difficulty breathing, complains of severe chest pain, and may have convulsions. Death can result within minutes.

### **FIRST AID**

- Call 911 immediately
- Administer prescribed medication if indicated in the Allergy Care Plan
- Epi-Pen to be injected by trained staff: Inject the tip of the syringe into the large muscle of the thigh through the clothing and the plunger depressed.
- Call school nurse and notify parent
- If the student becomes unconscious, check for breathing and pulse. Give CPR if indicated
- Record all given care on the Daily Log of Treatment Administered.

*It is important to remember that students who are having an asthma attack can be in serious danger. It's important to stay with them at all times and get emergency care at once.*

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### **IMPORTANT NOTICE TO PARENTS!**

UPON THE SIGNED WRITTEN REQUEST OF A PARENT OR LEGAL GUARDIAN, DISTRICT PERSONNEL MAY ASSIST PUPILS TO TAKE PRESCRIBED MEDICATIONS DURING THE REGULAR SCHOOL DAY ONLY UNDER ALL OF THE FOLLOWING CONDITIONS:

- The parent or legal guardian of the child requests that during school hours District personnel assist the pupil in taking medication, which is prescribed by a licensed physician. The request must be filed with the school site administrator or school nurse.
- The prescribing physician completes a signed statement which details the method, dosage amount, dose form and time schedules by which such medication is to be taken as well as the name of the medication, purpose of the medication, prescription date and expiration date (of medication), and length of time medication will be necessary.
- The parent or legal guardian of the pupil consents in writing to contact the prescribing physician relevant to the medical condition or medication and instructs the physician to answer any questions posed by District personnel regarding the medical condition or the medication prescribed for it.
- The parent or legal guardian is solely responsible for supplying all medication with which assistance is requested:
  - a. No prescribed medications may be brought to school by pupils.
  - b. Parents or guardians shall deliver or cause to be delivered by an adult or an authorized employee of a pharmaceutical supplier, any prescribed medications to be administered under the provisions of this policy.
  - c. Each medication must be in a separate container which clearly identifies the number of pills, capsules, or dosages contained therein.
- Whenever possible the parent or legal guardian should come to school to administer the medication.

### **NOTICE – SELF ADMINISTRATION OF ASTHMA INHALER AND EPINEPHRINE PEN**

Should parent and physician authorize self-administration of Asthma inhaler or Epinephrine Pen, the District and school personnel are released from civil liability in the event of an adverse reaction to medication, overuse, improper administration, breakage, loss theft, sharing, playing with or careless storage of medication.

### **NOTICE - PLEASE READ BEFORE SIGNING REQUEST**

A DISTRICT SCHOOL NURSE OR HEALTH CARE ASSISTANT IS NOT PRESENT AT THE SCHOOL SITE AT ALL TIMES OR ON ALL DAYS WHEN SCHOOL IS IN SESSION. THEREFORE, BECAUSE EMERGENCY ASSISTANCE MAY BE PROVIDED BY NON-MEDICALLY TRAINED DISTRICT PERSONNEL, PARENTS MUST ASSURE THAT PHYSICIANS PROVIDE COMPLETE, PRECISE, LEGIBLE DIRECTIONS AND INSTRUCTIONS. THE DISTRICT IS NOT RESPONSIBLE FOR NOTIFYING PARENTS BEFORE OR AFTER PRESCRIBED MEDICATION IS DEPLETED OR THE EXPIRATION DATE OCCURS. THIS REQUEST FOR DISTRICT ASSISTANCE WILL EXPIRE AT THE END OF THE SCHOOL YEAR IN, WHICH IT IS MADE.

**SIGNATURE ON FRONT OF PAGE INDICATES THAT I HAVE READ AND FULLY UNDERSTAND THE REQUIREMENTS FOR SCHOOL PERSONNEL ASSISTING WITH THE GIVING OF MEDICATION TO MY STUDENT(S) AT SCHOOL.**