VIROQUA AREA SCHOOLS EMERGENCY ACTION PLAN
INSECT STING / FOOD ALLERGY / LATEX ALLERGY

Health Care Provider to complete all areas above dotted line

Student: _____ Birth date: _____ Grade: _____

Allergy: _____

In this student, an insect sting or ingestion of an allergy producing food(s), even in small amounts, could lead to a severe, life-threatening reaction. Any suspected or known reaction requires close monitoring and immediate treatment of symptoms as set forth below. *If food substitutions are required due to severe reaction, please contact the Food Service Department (637-1645).

☐ **MONITORING SYMPTOMS ONLY** Student does not require medical assistance or intervention.	☐ Contact parent only if medical concern. ☐ Contact parent immediately regardless of reaction to allergen.
☐ **MILD SYMPTOMS ONLY (one or more):** MOUTH: itchy mouth SKIN: a few hives* around mouth/face; mild itch GUT: mild nausea/discomfort *raised, itchy bumps that appear suddenly	1. *GIVE oral **ANTIHISTAMINE**:* *Type _____, Dose _____* 2. *Contact parent to pick up student. Monitor closely until parent arrives.* 3. ***IF SYMPTOMS PROGRESS, INJECT EPINEPHRINE**:* *(see below)*

DO NOT HESITATE TO GIVE EMERGENCY TREATMENT IF UNCERTAIN OF SYMPTOM OR SEVERITY

☐ **SEVERE SYMPTOMS (one or more):** LUNG: short of breath, wheeze, repetitive cough HEART: pale, blue, faint, weak pulse, confused THROAT: tight, hoarse, trouble breathing or swallowing MOUTH: swelling of tongue or lips SKIN: many hives over body, facial swelling GUT: vomiting, cramping pain, nausea	1. ***INJECT EPINEPHRINE IMMEDIATELY** (outer thigh)* *Type _____, Dose _____* *(See label on auto-injector for directions)* 2. *Always call 911 after giving epinephrine.* 3. *Have child lie on back with feet raised.* 4. *Stay with student and monitor closely.* 5. *Alert parents.* 6. *For worsening symptoms, give second dose after 5 minutes; for persistent symptoms, give second dose of epinephrine after 10 minutes.*

This student is at very high risk of experiencing a severe reaction, therefore:

☐ *Give EPINEPHRINE immediately for any symptom following an insect sting or ingestion of _____.*

☐ *Give EPINEPHRINE immediately, even if no symptoms, following an insect sting or ingestion of _____.*

☐ *This student also has **asthma**. In addition to emergency medications:*

Give rescue inhaler (type) _____; (dose) _____ for any symptoms.

PARENTS MUST SUPPLY ABOVE MEDICATION IN ORIGINAL CONTAINERS

For Epinephrine Auto Injectors—Student may carry injector in school Yes No

_____ _____ _____ _____

Signature of Health Care Provider | Date | Phone | Hospital

I give my permission to the nurse or delegate(s) to administer medication to my child and to follow the written instructions provided by the Health Care Provider as indicated on my child's School Emergency Plan. I also give my permission to the school nurse to communicate with my child's Health Care Provider regarding health and safety in the school environment as it relates to his/her allergies.

_____ _____ _____ _____

Signature of Parent/Legal Guardian | Date | Phone | Alternate

_____ _____

Emergency contact name / relationship / phone | Emergency contact name / relationship / phone

Copies of plan provided to: Teacher☐ Specials☐ Special Ed☐ Bus Driver☐ Other _____

VIROQUA SCHOOL DISTRICT
PRESCRIPTION AND OVER-THE-COUNTER MEDICATION FORM

Medications are to be given at home whenever possible to avoid them being administered during school hours. If it is necessary for a student to receive medications at school, all appropriate portions of this form need to be completed before medication can be given at school and medication must come in the original container.

One form is required for EACH medication.

Student Name:	**Date of Birth:**	**School:**	**Grade:**
Medication Name:	**Dosage:**	**Time/Frequency**	
School Year or Effective Dates:	**Student's Practitioner/Clinic:**		
Reason/Diagnosis for Medication:			

Note: **For prescription medication**: Signed Parent Consent and signed Practitioner's Order required.
For non-prescription medication: Signed Parent Consent required.

PARENT/GUARDIAN CONSENT: (Complete for all Medication/Procedures at school)

- I request and authorize that this medication be administered at school by school personnel.
- **I will supply medication in its original, updated, properly labeled container**. (Request extra bottle from pharmacist.)
- **I further understand that all medication should be delivered to the school by parent/guardian/responsible adult.**
- This order is in effect for this school year only.
- 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 practitioner regarding this medication.
- I understand that medication may be given by non-medically trained school personnel.
- **My signature indicates that I have fully read and understand the above information.**

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

_____ _____ _____

Date **Parent/Guardian Signature** **Phone #**

PRACTITIONER'S ORDER: The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel.

Student and parent/guardian have been instructed and at school, student ***may carry & self-administer:*

Asthma Inhaler Yes_____ No_____ Epinephrine Auto Injector Yes_____ No_____

Practitioner's Name_____ Phone #_____ Fax#_____

Practitioner's Signature_____ Date_____

Clinic_____ Clinic Location_____