Food/Insect Allergy Action Plan

Student's Name: _____ Date of Birth: _____ Teacher: _____

ALLERGY to: _____ Asthmatic: ☐ Yes* ☐ No
*Higher risk for severe reaction

Step 1: Treatment

Symptoms		Give Checked Medication** ** To be determined by physician authorizing treatment	
• If a food allergen has been ingested, but no symptoms:		☐ Epinephrine	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat*	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart*	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other*		☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

The severity of symptoms can change quickly. *Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly _____
Name of Medication

Antihistamine: _____
Medication / Dose / Route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Step 2: Emergency Calls

1. Call 911 (EMS: _____). State than an allergic reaction has been treated, and additional epinephrine may be needed.
2. Emergency contacts:

	Name/Relationship	Phone Number(s)	
a)	_____	1) _____	2) _____
b)	_____	1) _____	2) _____

Even if Parent/Guardian cannot be reached, do not hesitate to medicate or take child to medical facility.

☐ I give Forsyth County School employees permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

☐ I certify that this child has a medical history of allergy and has been trained in the use of epinephrine, and is judged by me to be:

_____ capable of carrying and self-administering the listed medication(s),

_____ **NOT** capable of carrying and self-administering the listed medication(s).

Physician Name (PRINT)	Physician Signature	Date
Parent Name (PRINT)	Parent Signature	Date

Reviewed by: _____ Date: _____

*Refer to 504 coordinator if appropriate

Revised: July 2023

FORSYTH COUNTY SCHOOLS

Food Allergy Action Plan – Parent Questionnaire

Student: _____ **Date of Birth:** _____

Mother/Guardian: _____ **Phone #1:** _____ **Phone #2:** _____

Father/Guardian: _____ **Phone #1:** _____ **Phone #2:** _____

Allergy: _____

Food Allergy Accommodations

- Foods and alternative snacks will be approved or provided by parent/guardian.
- Parent/guardian should be notified of any planned parties as early as possible.
- Classroom projects should be reviewed by the teaching staff to avoid specified allergens.
- Student is responsible for making his/her own food decisions. ☐ Yes ☐ No
- When eating, request student eats in a specific area. ☐ Yes ☐ No
  - Where? _____
- No restrictions
- Other (specify)

Bus Concerns –Transportation should be alerted to student's allergy.

- This student carries Epi auto-injector on the bus? ☐ Yes ☐ No
- Epi auto-injector can be found in ☐ Backpack ☐ Waist pack ☐ On Person
  Other (specify): _____
- Student will sit at front of the bus. ☐ Yes ☐ N o
- Other (specify): _____

Field Trip Procedures – Epi auto-injector must accompany student during any off-campus activities.

- The student must remain with the teacher or parent/guardian during the entire field trip? ☐ Yes ☐ No
- Staff members on trip must be trained regarding Epi auto-injector use and this health care plan (plan must be taken).
- Other (specify): _____

ADDITIONAL EMERGENCY CONTACTS

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____

- I request this medication to be given as ordered by the licensed health professional (LHP) (i.e., doctor, nurse practitioner, PAC).
- I give health services staff permission to communicate with the LHP/medical office staff about this plan and medication.
- I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff.
- I release school staff from any liability in the administration of this medication at school.
- Medical/medication information may be shared with school staff working with my child and 911 staff if they are called.
- All medication supplied must come in its originally provided container with instructions as noted above by the LHP. Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- I request and authorize my child to carry and/or self-administer their medication. ☐ Yes ☐ No
- Students who misuse or abuse medications may be subject to violating the Code of Conduct.

_____

Parent/Guardian Print Name **Signature** **Date**

Device(s) if any: _____ Expiration date(s): _____

_____

School Nurse Print Name **Signature** **Date**

A meeting will be scheduled with parent(s)/ guardian(s) and school staff.

FORSYTH COUNTY SCHOOLS

Administration of Medication Information

The administration of medication to students during the school day presents an increased concern and awareness of the need to have written procedures.

Medication may be dispensed to students with the assistance of school personnel whenever physicians find it necessary to prescribe medication to be taken during school hours. School personnel will cooperate with parents in this regard by providing a place for the medication to be stored; however, the major responsibility for a child taking medication at school rests entirely with the child's parents.

A nurse is not always available to assist in the administration of the medication. The student may be assisted by an adult designated by the principal.

Prescription and non-prescription medication will be given to students by school personnel only when the following guidelines are observed:

***All medication MUST be in its original container and MUST be brought to school by the parent or guardian**. Medications brought in baggies or other unmarked containers will not be given. Prescription medication must be in the pharmacy container labeled with the child's name, date, name of medication, name of the prescribing physician, time(s) the medication is to be given and name of the pharmacy filling the prescription. We request that you ask the pharmacist to give you two labeled prescription bottles so that you have one bottle at home and one at school.

*A "Request for Administration of Medication" form (see back) must be completed by the parent/guardian (and physician if the medication needs to be given for longer than two weeks - such as (Ritalin) and sent to school along with the medication.

***Do not send medication to school which needs to be given daily or two/three times a day unless the physician specifically states a time during the school day which it is to be given.** An antibiotic which is to be given three times daily can be given before the child leaves for school, when he/she gets home, and at bedtime.

*School personnel cannot give medication that contains aspirin to students under 18 years old due to the correlation with Reyes Syndrome. Examples are Pepto Bismol, Excedrin Migraine, Goody's Powder.

The safety and well-being of your child is our concern. With your understanding and cooperation, we can eliminate much of the unnecessary medications that are brought to school and ensure that our students who do need to take medication at school will receive it appropriately. If you have any questions regarding medications, please call your child's school or you may call the school nurse.

Authorization For Students To Carry a Prescription Inhaler, Epinephrine Auto Injector,

FORSYTH COUNTY SCHOOLS

Request for Administration of Medication

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.
Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Forsyth County Board of Education and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

- All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia.
- Medications must be in the original container.
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
- All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Forsyth County care plan.
- Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
- A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
- MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

Name of Student: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Medication: _____ **Date of Prescription:** _____

Physician's Name: _____ **Physician's Phone:** _____

Dosage & Time of Administration: _____

Allergies: _____ **Stop Medication on:** _____

Statement of Parent or Guardian

I hereby give my permission for my child to receive this medication at school.

_____

Parent/Guardian Name (Print) Parent/Guardian Signature Date

_____

Home Phone Work Phone Cell phone

To be completed by Physician for long-term medications (more than two weeks):
"Physician" as defined in Article 2 of the Medical Practice Act of Georgia

Condition/Illness Requiring Medication: _____

Possible Side Effects of Medication: _____

Other Medication Student is Taking: _____

Physician's Signature: _____ **Date:** _____

Parent/Guardian Picked Up Medication: _____ **Date:** _____

Parent Signature: _____ **Nurse:** _____ **Date:** _____

Request for Administration of Medication Revised: July 2023

Request for Administration of Medication

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I hereby release and discharge the Forsyth County Board of Education and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

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I understand that:

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- Medications must be in the original container.
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
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- MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

Name of Student: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Teacher:** _____

Medication: _____ **Date of Prescription:** _____

Physician's Name: _____ **Physician's Phone:** _____

Dosage & Time of Administration: _____

Allergies: _____ **Stop Medication on:** _____

Statement of Parent or Guardian

I hereby give my permission for my child to receive this medication at school.

_____

Parent/Guardian Name (Print) Parent/Guardian Signature Date

_____

Home Phone Work Phone Cell phone

To be completed by Physician for long-term medications (more than two weeks):
"Physician" as defined in Article 2 of the Medical Practice Act of Georgia

Condition/Illness Requiring Medication: _____

Possible Side Effects of Medication: _____

Other Medication Student is Taking: _____

Physician's Signature: _____ **Date:** _____

Parent/Guardian Picked Up Medication: _____ **Date:** _____

Parent Signature: _____ **Nurse:** _____ **Date:** _____

Request for Administration of Medication Revised: July 2023

Authorization For Students to Carry a Prescription Inhaler, Epinephrine Auto Injector, Insulin, and Diabetic Supplies, or Other Approved Medication

_____needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or

_____prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home.

Name of Medication: _____

Practice Name | Address | Telephone Number

Examiner's Name (Please Print) | Credentials

Examiner's Signature | Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the school nurse each time I take my medication.

_____ _____

Student's Signature *Date*

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry, and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above- named student administers his/her own medication.

Parent/Guardian Name (Please Print) | Parent/Guardian Signature | Date