Education at its best.

MONTELLO SCHOOL DISTRICT

District Phone: 608-297-7617 Fax: 608-297-7726

Allergy Treatment & Emergency Plan

STUDENT:_____ Birthdate:_____

School:_____Grade/Class:_____Parent Name/Phone Number:_____

Allergy to:_____

If Exposed by: ☐ Being stung ☐ Ingesting ☐ Inhaling ☐ Skin contact (**wash with soap and water if exposed**)

Asthmatic: ☐ Yes (higher risk for severe reaction) ☐ No

Has Own EpiPen: ☐ Yes (and the dose is _____ mg.) ☐ No

Antihistamine (given orally): ☐ Benadryl(Diphenhydramine) _____mg. ☐ Other_____

Treatment as Indicated Below:

STAY WITH THE STUDENT. IF AT SCHOOL, CALL FOR MEDICAL TEAM

If exposed, but no symptoms:	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other:_____
Mouth: Itching, tingling	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other:_____
Face: swelling of lips, tongue, mouth, or face	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other: _____
Skin: Hives, itchy rash, swelling	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other:_____
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other: _____
**Throat: Tightness of throat, hoarseness, hacking cough	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other: _____
**Lung: Shortness of breath, repetitive coughing, wheezing	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other: _____
**Heart: Fainting, pale, blue, weak, low BP	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other:_____
Other:_____	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other: _____
If reaction is getting worse / several above areas are affected	☐ Antihistamine	☐ Epinephrine/call 911	☐ Other: _____

Additional directions:_____

(see next page)

PARENT/GUARDIAN CONSENT:

This student is capable of self-administration and may carry medication & self-administer in school. ☐ Yes ☐ No

- 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 if able.)
- This order is in effect for this school year unless otherwise indicated.
- 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 physician regarding this medication or the conditions for which it is prescribed.
- I further understand the parent/guardian/responsible adult should deliver all medication to the school.
- I give my permission to have my child's photo displayed on this form.
- I understand that non-medically trained school personnel will give medication.
- I agree to hold the School District, 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 at school.
- My signature indicates that I have fully read and understand the above information.

_____	_____	_____
Signature of Parent/Legal Guardian	Phone Number	Date

PHYSICIAN 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 will be given by non-medically trained school personnel.

Please contact me if the following symptoms occur:_____

Physician Name: _____ Clinic:_____Fax #: _____

Address:_____Phone #:_____

Physician Signature: _____ Date: _____

Reviewed 11/2022