MEDICATION - a separate Medication Request Form is required for each medication		
Epinephrine Brand (eg. EpiPen):	Dose:	Side Effects:
Antihistamine Name:	Dose:	Side Effects:
Other: (eg, asthma inhaler)	Dose:	Side Effects:

LOCATION OF EPINEPHRINE - please mark all that apply

☐ Backpack ☐ Office ☐ Other _____

PARENT TO COMPLETE

As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.
* I understand the information contained in this plan will be shared with Madison School District staff on a need-to-know basis.
* I give permission to the District Nurse and other Madison School District staff to follow this Emergency Care Plan and administer medication as directed.
* I agree to release, indemnify, and hold harmless the District Nurse and other Madison School District staff from lawsuits, claim expense, demand or action, etc., against them for helping my child with allergy treatment, provided the personnel are following physician instruction as written in this emergency action plan.
* I understand I am responsible for maintaining necessary supplies, medication, and equipment.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new Medication Request Form and Emergency Care Plan Form must be completed before the school staff can administer the medication.
* I understand that if any emergency medication is administered at school, Emergency Medical Services (EMS) will be notified for evaluation, monitoring, and possible further treatment.
* I understand that if my child is given emergency medication, he/she may not remain at school unless I can be present to monitor him/her for adverse reactions. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive.

Parent Name:	**Phone:**
Parent Signature:	**Date:**

HEALTHCARE PROVIDER TO COMPLETE - please read, check one of the options, and sign below

☐ It is **medically appropriate** for the student to **self-carry and self-administer** the Epinephrine Auto Injector (EAI), *when able and appropriate*, and should be in possession of the EAI at all times. Please have school personnel administer the EAI if student is unable to do so. ***** The student has been trained and has demonstrated proper medication administration procedure.***

☐ It is **medically appropriate** for the student to self-carry the EAI, **but NOT self-administer** the EAI. This student should be in possession of the EAI at all times. Please have school personnel administer the EAI in an emergency.

☐ It is **NOT medically appropriate** for the student to **self-carry or self-administer** the EAI. Please have the designated school personnel maintain (see location above) and administer the EAI in an emergency.

This student is under my care. This Allergy & Anaphylaxis Action Plan reflects my plan of care.

Healthcare Provider Name:	**Phone:**
Healthcare Provider Signature:	**Date:**
District Nurse has reviewed this plan**:**	**Date:**