



MISD Allergy/Anaphylaxis Action Plan & Medication Authorization

Student's Name: _____ ID# _____ DOB _____ Grade _____ Teacher _____

ALLERGY TO: _____ Asthmatic or History of Asthma

Epi Pen Qty: _____ Location: Clinic Trainer/Coach On his/her person

Medication Treatment for Allergic Reaction:

<input type="checkbox"/>	Antihistamine _____ mg	
	Special Instructions:	
<input type="checkbox"/>	Epinephrine Injection _____ mg	
	Special Instructions:	

Action Plan for Exposure:

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	Epinephrine	Antihistamine
Other:	Epinephrine	Antihistamine

❖ **Potentially life threatening**

Action Plan for Minor Reaction:

Exposure to allergen, but no symptoms	Epinephrine	Antihistamine
Have student resume activities if:		
Contact parent if:		

- I hereby authorize _____ to carry and self administer his/her Epinephrine injection medication as prescribed while on school property or school related events.
- I do **NOT** authorize _____ to carry and self-administer the above medication while on school property or school related events.

Physician's Name: _____ Telephone Number: _____

Physician's Signature: _____ Date: _____

If a parent/guardian cannot be reached, do not hesitate to Call 911/EMS

Parent/Guardian Signature _____ Date: _____

Parent Telephone _____ Emergency Contact Name _____ Emergency Telephone Number _____

Student Signature (if authorized to carry his/her Epi-Pen medication at school) _____ Date _____

Student Demonstrates knowledge of proper use, procedure and school policy regarding the responsibility of carrying medication on his/her person.

Nurse Signature _____ Date _____