

## Emergency Action Plan and Order: Severe Allergy in School

*(To be printed back/front)*



Mecklenburg County Public Health

<b>School Name</b>	<b>School Phone #</b>	<b>Fax:</b> (704) 432-2079 (School Health)	<b>For School Use Only</b>
			<b>Date Received/Receiver's Signature:</b>
<b>Student's Name (Please print.)</b>	<b>Student's Date of Birth</b>		<b>Medication Received?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
			<b>Date Approved/Nurse's Signature</b>
			<b>Entered in EHR?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
<b>Parent/Guardian: Please read both pages of the Action Plan. Sign and date the bottom of both pages to show your agreement.</b>			<input type="checkbox"/> Student Self Carries <input type="checkbox"/> Medication in Health Room <input type="checkbox"/> Medication in Classroom

### Important Information about Medication Administration in CMS Schools

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| <ul style="list-style-type: none"> <li>When possible, medications should be taken before or after school. Administration of non-prescription medications at school is discouraged.</li> <li>Written parent/guardian consent and an order from a healthcare provider licensed in North Carolina are required for administering prescription and over-the-counter medications at school (CMS Policy JLCD/Regulation JLCD-R). Contact the school nurse for help if relocating from another state with orders from an out-of-state provider. Some medications may not be suitable for a school setting. Additional documentation may be required for some medications (examples: research medications, medications with potential for immediate serious side effects). Contact the school nurse if you have questions.</li> <li>Unless changed in writing, this plan will be used for the entire school year within which it was written.</li> <li>Medications are given by a nurse or trained CMS staff.</li> </ul> | <ul style="list-style-type: none"> <li>No medication will be given at school until this authorization has been approved by a school nurse.</li> <li>New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.</li> <li>Each medication must be in the original labeled container from the pharmacy or healthcare provider's office. Some pharmacies will provide an extra container for school use.</li> <li>Information about this medication and the student's health may be shared with other school staff or agents of the school to help assure the student's safety and success at school.</li> <li>The school nurse may contact the healthcare provider who prescribed the medication and the pharmacy where the prescription was filled to discuss this medication and the student's health.</li> </ul> |
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<b>Healthcare Provider's Name / Address / Phone / Fax (please print or use stamp)</b>	<b>Parent/Guardian Contact Information (please print)</b>	
	Parent/Guardian	
	Phone:	Phone:
	Parent/Guardian	
	Phone:	Phone:

I have read and understand the "Important Information about Medication Administration in CMS Schools" in this action plan. I give permission for my child to receive the medications noted in this plan during school hours. I give permission for the healthcare provider, pharmacist and their staff to provide information to the school nurse about this medication and my child's health. On behalf of my child, I release the Charlotte-Mecklenburg Board of Education, their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

*Write on line below.*

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Parent's/Guardian's Name (print) Signature Date

<b>Student's Name:</b>	<b>Student's Date of Birth:</b>
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**To be completed by student's health care provider:**  
**If student is approved to self-carry and/or self-medicate, also complete the identification section and Section 3 of the Medication Authorization for CMS Students (Med 1) form. Attach this form to the Medication Authorization form.**

<b>List student's allergies:</b>  	<b>Some Signs/Symptoms of Severe Allergic Reaction:</b> <ul style="list-style-type: none"> <li>➤ Trouble breathing</li> <li>➤ Wheezing</li> <li>➤ Hoarseness (changes in the way voice sounds)</li> <li>➤ Hives (raised reddened rash that may itch)</li> <li>➤ Severe itching</li> <li>➤ Swelling of the face, lips, mouth, or tongue</li> <li>➤ Skin rash, redness, or swelling</li> <li>➤ Fast heartbeat</li> <li>➤ Weak pulse</li> <li>➤ Feeling very anxious</li> <li>➤ Confusion</li> <li>➤ Stomach pain</li> <li>➤ Dizziness, fainting, or "passing out" (unconsciousness)</li> <li>➤ Tightness in the chest or throat</li> <li>➤ Difficulty swallowing, drooling, or slurred speech</li> <li>➤ Tingling around the face or mouth</li> </ul>
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**If ingestion of or contact with allergen is suspected and/or symptoms of a severe allergic reaction occur immediately give medication listed below.**

Name of Medication	Dosage	Route	Possible Side Effects

**If Epinephrine is given (e.g., epinephrine auto-injector):**

- 1. Stay with the student. Monitor alertness and breathing. Provide CPR if necessary.**
- 2. Have another person: ■ Call 911 immediately. ■ Notify school nurse, parent/guardian and principal.**

In my professional opinion, the medication noted above is necessary for this student if an allergic reaction occurs at school.	
Health Care Provider Name (print):	
Health Care Provider Signature:	Date: <span style="float: right;"> </span>

I have reviewed this Emergency Action Plan and agree with this plan. I agree to school staff being trained to administer the medication.	
Preferred Hospital:	
Parent/Guardian Signature:	Date: <span style="float: right;"> </span>