COVINA-VALLEY UNIFIED SCHOOL DISTRICT - STUDENT SERVICES

ANAPHYLAXIS ACTION PLAN

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Name_____ DOB_____ School_____

I request that designated District personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I assume full responsibility for supplying all medication and shall deliver it, or have it delivered, to the school by another responsible adult, and agree to the District policies and procedures. I authorize the District to communicate with the physician below regarding my child's medical condition and/or the medication prescribed for it.

Signature Parent/Guardian and Telephone: _____ Date: _____

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER:

Allergy to: _____ Asthmatic: ☐Yes ☐No

Symptoms	Give checked medication determined by Physician
If a food has been ingested, or stung by bee but no symptoms	☐Antihistamine ☐Epi-Pen
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐Antihistamine ☐Epi-Pen
Skin: Hives, itchy rash, swelling of the face or extremities	☐Antihistamine ☐Epi-Pen
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Antihistamine ☐Epi-Pen
Throat: Tightening of throat, hoarseness, hacking cough	☐Antihistamine ☐Epi-Pen
Lung: Shortness of breath, repetitive coughing, wheezing	☐Antihistamine ☐Epi-Pen
Heart: Thready pulse, fainting, pale, blueness	☐Antihistamine ☐Epi-Pen
Other symptoms:	☐Antihistamine ☐Epi-Pen
If reaction is progressing (several of the above areas affected)	☐Antihistamine ☐Epi-Pen

The severity of symptoms can quickly change and be potentially life-threatening. Call 911 if EpiPen is administered

DOSAGE:

Epinephrine: inject into outer thigh ☐ EpiPen ☐EpiPen Jr. ☐Adrenaclick 0.15mg ☐Adrenaclick 0.3 mg ☐Auvi-Q 0.3mg ☐Twinject 0.3mg ☐Twinject 0.15mg ☐Other: _____

Other medication: give _____

medication/dose/route/frequency

Describe precautions, side effects, storage, or special instructions: _____

_____

☐In my professional opinion, the student's well being is in jeopardy unless the medication is carried on his/her person while at school. I certify that this student has demonstrated knowledge of correct dosage and usage and is physically, mentally, and behaviorally capable of administering this medication. Medication is to be used by the above student as indicated above.

☐This student requires assistance, keep medication in the health office

_____

Print Name of Physician Signature of Physician

_____

Address Telephone Date

Thank you, ***Covina-Valley Health Services*** **Office**: 626-974-6435 ; **Fax**: 626-974-6436

THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR IN WHICH MADE ALL MEDICATION NEEDS TO BE PICKED UP ON THE LAST DAY OF SCHOOL OR IT WILL BE DISCARDED

Rev. 4/08, 12/17, 5/18, 9/19, 02/23, 5/23

COVINA-VALLEY UNIFIED SCHOOL DISTRICT - SERVICIOS ESTUDIANTILES

PLAN DE ACCIÓN DE ANAFILAXIA

PADRES/TUTOR LEGAL DEBEN COMPLETAR:

Nombre del Estudiante _____ DOB _____ Escuela _____

Solicito que el personal designado del Distrito ayude a mi estudiante a tomar el medicamento de acuerdo a las instrucciones proveídas abajo por el médico. Asumo toda la responsabilidad de proveer todo el medicamento y debo entregarlo, o que sea entregado a la escuela por otro adulto responsable, y acepto las pólizas y procedimientos del Distrito. Autorizo que el Distrito se comunique con el médico abajo tocante la condición médica de mi hijo y/o el medicamento recetado para la misma.

Firma de Padres/Tutor Legal y Teléfono: _____ Fecha: _____

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER / (SER COMPLETADO POR UN MÉDICO CON LICENCIA)

Allergy to: _____ Asthmatic: ☐Yes ☐No

Symptoms	Give checked medication determined by Physician	
If a food has been ingested, or stung by bee but no symptoms	☐Antihistamine	☐Epi-Pen
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐Antihistamine	☐Epi-Pen
Skin: Hives, itchy rash, swelling of the face or extremities	☐Antihistamine	☐Epi-Pen
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐Antihistamine	☐Epi-Pen
Throat: Tightening of throat, hoarseness, hacking cough	☐Antihistamine	☐Epi-Pen
Lung: Shortness of breath, repetitive coughing, wheezing	☐Antihistamine	☐Epi-Pen
Heart: Thready pulse, fainting, pale, blueness	☐Antihistamine	☐Epi-Pen
Other symptoms:	☐Antihistamine	☐Epi-Pen
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Other medication: give _____

medication/dose/route/frequency

Describe precautions, side effects, storage, or special instructions: _____

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☐This student requires assistance, keep medication in the health office

_____

Print Name of Physician Signature of Physician

_____

Address Telephone Date

Gracias, ***Servicios de Salud de Covina-Valley*** **Oficina**: 626-974-6435 ; **Fax**: 626-974-6436

ESTA PETICIONA EXPIRA AL FIN DEL AÑO ESCOLAR YEAR CUAL REQUIERE QUE TODOS LOS MEDICAMENTOS SE RECOJAN EL ULTIMO DIA DE ESCUELA O SERÁ DESECHADO

Rev. 4/08, 12/17, 5/18, 9/19, 02/23, 5/23