

**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 marked medication as determined by physician
If a food has been ingested, or stung by bee but no symptoms	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Throat: Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Lung: Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Heart: Thready pulse, fainting, pale, blueness	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Other symptoms:	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
If reaction is progressing (several of the above areas affected)	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine

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

Name of Medication: _____ **Dosage Prescribed:** _____

Time/Frequency: _____ **Route:** _____

Name of Medication: _____ **Dosage Prescribed:** _____

Time/Frequency: _____ **Route:** _____

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*: 626-974-4500 ; 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

**COVINA-VALLEY UNIFIED SCHOOL DISTRICT - SERVICIOS ESTUDIANTILES
PLAN DE ACCIÓN DE ANAFILAXIA/ANAPHYLAXIS ACTION PLAN**

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:

Allergy to: _____ Asthmatic: Yes No

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Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
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Lung: Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
Heart: Thready pulse, fainting, pale, blueness	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epinephrine
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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