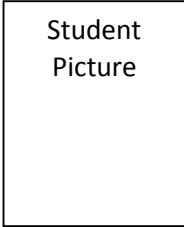


North Thurston Public Schools
 305 College Street NE
 Lacey, Washington 98516-5390
 www.nthurston.k12.wa.us

Student Support Services
 Phone: (360) 412-4484
 Fax: (360) 412-4555

SCHOOL EMERGENCY ACTION PLAN/MEDICATION ORDER

Student: _____ DOB: _____ Teacher/Grade: _____
 Parent/Guardian: _____ Phone: (H) _____ (O) _____
 Second Contact Person: _____ Phone: _____
SEVERE ALLERGY TO: _____ (Allergen) ASTHMATIC: Yes No



SIGNS OF AN ALLERGIC REACTION

- THROAT* itching and/or sense of tightness in the throat, hoarseness, and hacking cough
- LUNG* shortness of breath, repetitive coughing and/or sneezing
- HEART* "thread" pulse, fainting and/or feeling may "pass out"
- MOUTH itching and swelling of the lips, tongue or mouth
- SKIN hives, itchy rash and/or swelling about the face or extremities
- GUT nausea, abdominal cramps, vomiting and/or diarrhea

The severity of symptoms can quickly change. *Symptoms in any of the top three systems can be immediately life-threatening and symptoms in the bottom three can progress to a potentially life-threatening situation!

IN THE PRESENCE OF ANY OF THE ABOVE SYMPTOMS a child with severe allergies should be monitored continuously.

ACTION

1. If exposure to allergen is suspected, or if child exhibits ANY symptoms, give Epi-pen (inject into thigh and hold for 10 seconds)
2. **CALL 911**
3. Call Parent/Guardian

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!!

Registered nurses cannot delegate assessment and clinical judgment to unlicensed school staff, therefore, Benadryl will not be given first and there cannot be a "wait and watch" period of time. Epinephrine will be administered as ordered.

Medication Orders: To be completed and signed by Licensed Health Professional

MEDICATION NAME	HOW MUCH	WHEN TO USE
_____	_____	_____
Permission to carry Epi-pen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Permission to carry Inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of Licensed Health Professional	Name (Please print or type)	Date
Phone	FAX	Address
		City
		Zip Code

Signature of Parent or Legal Guardian _____ Date _____
 Signature of School Nurse _____ Date _____

In health room?	<u>Epi pen</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Inhaler</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
Carries in <input type="checkbox"/> Backpack <input type="checkbox"/> Purse <input type="checkbox"/> Other: _____		
Sports Played _____		
<input type="checkbox"/> Rides bus # _____ or <input type="checkbox"/> Drives _____		