

SCHOOL ADMINISTRATIVE DISTRICT NO.59

PLEASE FAX TO

School Nurse, Madison Junior High
Telephone: (207)-696-3381 Ext. 4226
Fax: (207)-696-5640

PLEASE FAX TO:

School Nurse Madison High School
Telephone: (207)696-3395
Fax: (207)696-5644

PLEASE FAX TO:

School Nurse, Madison Elementary
Telephone: (207)-696-4607
Fax: (207)-696-5639

Maine School Allergy Action Plan

Student's Name _____ DOB _____

Grade _____ School _____

Parent Emergency Contact _____

(Phone)

TO BE COMPLETED BY THE STUDENT PARENT:

<p><input type="checkbox"/> I give permission for my child to carry an EpiPen at school.</p> <p><input type="checkbox"/> I give permission for the school nurse and my child's health provider to exchange information about my child's allergy.</p> <p><input type="checkbox"/> Student/family chooses to keep EpiPen in school nurse office.</p> <p>Parent Signature : _____ Date: _____</p>
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TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER: Allergy to:

<p>FOOD: Peanuts, Tree nuts, Seafood, Dairy, Other Specify</p> <p>INSECT: Bees, Other Specify</p> <p>Other Allergy Specify:</p>
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ACTION FOR MINOR REACTIONS:

Medication: _____
(Medication/dose/route)

- Contact Parent
- Observe student for _____ minutes

List symptoms (e.g. rash, swelling, or itching at site)

ACTION FOR MAJOR REACTIONS:

Epinephrine: inject intramuscularly (circle one) • EpiPen • EpiPen Jr.

Other medication: _____ (Medication/dose/route)

Call EMS _____

Contact Parent

Contact School Nurse

This student has the knowledge and skills to carry and use an EpiPen.

This student does not have the knowledge and skills to carry and use an EpiPen.

Other _____

List symptoms (e.g. difficulty breathing, generalized swelling or itching, wheezing, fainting)
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Physician/Health care provider _____

Physician/Health care provider signature: _____ Date: _____

School Nurse: _____ Date: _____