Hustisford School District

District Office	Jr./Sr. High School	John Hustis Elementary
845 S. Lake St. · P.O. Box 326 Hustisford, WI 53034 (920) 349-8109	845 S. Lake St. · P.O. Box 326 Hustisford, WI 53034 (920) 349-3261	600 S. Hustis. St · P.O. Box 386 Hustisford, WI 53034 (920) 349-3228
Heather Cramer District Administrator	**Clint Bushey** Principal	**Heather Cramer** Principal
Jessica Holtz Director of Financial Services	**Dena Serwe** Director of Special Education/Psychologist	

Allergy Treatment & Emergency Plan

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student:_____ **Grade/Class:**_____ **DOB:**_____ **Weight:** _____

Allergy: _____ **Asthmatic**: ☐ Yes (higher risk for severe reaction) ☐ No

Epinephrine (given by injection): ☐ EpiPen ☐ EpiPen Junior

Antihistamine (given orally): ☐ Benadryl**(**Diphenhydramine) _____mg ☐ Other _____

Provider Name: _____ **Phone Number:** _____

AT THE END OF THE SCHOOL YEAR, PLEASE (check one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my student

My student may self-carry & self-administer their inhaler in school. ☐ Yes ☐ No

- I authorize that this medication/procedure be administered at school, potentially by non-medically trained personnel.
- I will supply medication in its original and properly labeled container.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I agree staff may exchange information with the provider regarding this medication/conditions for which it is prescribed.
- I understand the parent/guardian/responsible adult should deliver all medication to the school.
- I understand that this consent is for the current school year (including after hours school events & on field trips.)
- I consent to the release of the information contained in this Allergy Treatment Plan to staff members who may need to know this information to maintain my child's health and safety.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

Parent/Guardian Signature: _____ **Date:** _____

Home of the Falcons

Reviewed 5/2023

TO BE COMPLETED BY THE PROVIDER:

The above medication/procedure is to be administered/performed in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel. My signature indicates that I have read and fully understand the above information.

This student may self-carry & self-administer their inhaler in school. ☐ Yes ☐ No

Provider Signature: _____ **Date:** _____

Symptoms of Mild Allergic Reaction -> Give Antihistamine and Monitor

- Itching/Sneezing
- Hives
- Nausea/vomiting/diarrhea
- Swelling around eyes

Symptoms of Severe Allergic Reaction/Anaphylaxis -> Give Epinephrine

- **Shortness of breath, persistent cough, wheezing**
- **Pale/blue skin**
- **Weak pulse**
- **Feeling dizzy or lightheaded**
- **Trouble swallowing, sore or tight throat**
- **Swelling of lips or tongue**
- **Altered level of Consciousness**
- **Multiple Symptoms listed above for Mild Allergic Reaction**

Anaphylaxis First Aid:

- **Give epinephrine right away - note time**
- **Call 911**
- **Stay child child and have them lie down**
- **Call parent/guardian**
- **If symptoms do not improve with in 5 minutes, give second dose of epinephrine**
- **Place student on their side if the begin to vomit**