








Please be mindful that this form expires after one year.

Patient Name (Last, First, Middle)		Date of Birth	Expiration Date of Action Plan
Patient Weight		History of Asthma: Y/N	
Patient's known severe allergies			
<input type="checkbox"/> If checked, give epinephrine immediately if the allergen was LIKELY eaten/inhaled/touched, for ANY symptoms.		<input type="checkbox"/> If checked, give epinephrine immediately if the allergen was DEFINITELY eaten/inhaled/touched, even if no symptoms are apparent.	
U <input type="checkbox"/> Epi Pen Jr. (0.15mg) <input type="checkbox"/>			
<p> *Symptoms generally subside immediately after the first dose. If symptoms do not subside after 4-6 minutes, or if symptoms subside and then return, administer a second dose* </p>			
Health Care Provider		Provider's Phone Number	
Parent/Guardian Name		Parent/Guardian Phone Number	
Emergency Contact Name	Home Number	Work Number	Cellular Number
1.			
2.			
3.			

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 <p>V\o' · Itchy/runny nose, sneezing</p>	 <p>U\yu= Itchy mouth</p>	 <p>oM' · A few hives, mild itch</p>	 <p>8yu' · Mild nausea/ discomfort</p>
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Administer additional medications following epinephrine: such as an antihistamine if wheezing.

Lay the student flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.

Ensure emergency responders transport student to emergency room, even if symptoms resolve. Student should remain in ER for at least 4 hours because symptoms may return.

If undersigned epinephrine auto-injector was administered, follow protocols to contact the Office of State Superintendent of Education for re-placement.

Contact Health suite personnel with updated information about allergies, should require submission of a NEW action plan by provider - DC Health

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Healthcare Providers Initials

- _____ This student was trained and is capable of self-administering with the epinephrine auto-injector.
Where is the Epi-Pen located? _____ (self-carry student, in nurse suite or _____ other)
- _____ This student is allowed to administer the epinephrine auto-injector.
- _____ This student is not approved to self-medicate.

- As the Parent/Guardian, I hereby authorize a trained school employee to administer medication to the student.
- As the Parent/Guardian, I hereby authorize this student to possess and self-administer medication.

I hereby acknowledge that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under D.C. Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct