Campus Reddix Center

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Northside Independent School District
Health Services Department
Anaphylaxis/Insect Allergy Action Plan
Physician Order Form

Name:_____ **Student ID#:** _____ **D.O.B.** __/__/__ **Wt:** ____ **lbs**

Allergy:_____

Medication/Doses

Epinephrine (brand/dose): _____

Antihistamine (brand/dose): _____

Is the student Asthmatic? ____Yes ____No Bronchodilator (brand/dose): _____

Treatment Plan: Physician to check appropriate medication(s)

Allergen Exposure – no symptoms	___Epinephrine ___Antihistamine
Respiratory – wheezing, shortness of breath, coughing	___Epinephrine ___Antihistamine
Cardiovascular – low blood pressure, weak pulse, pallor/blue	___Epinephrine ___Antihistamine
GI – nausea, vomiting, diarrhea, cramping	___Epinephrine ___Antihistamine
Skin – hives, itching, rash, swelling of face/extremities	___Epinephrine ___Antihistamine
Mouth – swelling lips/tongue, itching, tingling	___Epinephrine ___Antihistamine
Throat – tightening, hoarseness, coughing	___Epinephrine ___Antihistamine
Other - _____	___Epinephrine ___Antihistamine
Symptom Worsening - _____	___Epinephrine ___Antihistamine

Parent consents for nurse follow up with physician ___Yes ___No _____ _____
Parent Signature Date

Physician recommendations for medication self-administration: (Initial one)

_____The student above has been instructed by me in the proper way to use his/her medication(s). It is my professional opinion that he/she be allowed to carry and self –administer the above medications while on school property or at school related events.

_____The student above in my professional opinion should NOT be allowed to carry and self-administer any of the above medication(s) while on school property or at school related events.

_____ _____
Physician Signature / Phone # **Date**

3300 -1 1b
3 years

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