Student Name _____

Oxford Community Schools
SEVERE ALLERGY Medical Action Plan (MAP)

Student's Name _____
Date of birth _____ **School** _____
Age _____ **Grade** _____ **School Year** _____

Child's picture

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medications.

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

CONTACT INFORMATION

	Call First	Try Second
Parent/ Guardian:	Name: _____	Name: _____
	Relationship: _____	Relationship: _____
Phone:	Home: _____	Home: _____
	Cell: _____	Cell: _____
	Work: _____	Work: _____

Call Third (If a parent/guardian cannot be reached)
Name: _____ Relationship: _____
Address: _____ Phone: _____

ALLERGIC HISTORY

Has your child ever been given an epinephrine shot for an allergic reaction? YES NO

Does your child have Asthma? (If yes, at a higher risk for severe allergic reaction) **YES NO**

If your child needs medication at school for asthma, please complete a separate ASTHMA Medical Action Plan

List all Allergic FOOD If nuts, please specify by circling one or both: Peanut Tree Nut

I request that my child sit at a no nut food allergy friendly table for meals

List of Different SEVERE ALLERGIES (such as, Insect sting or Latex) **YES NO**

List of other foods that should be avoided, but are not a risk for a severe allergic reaction

If my child is to self-carry epinephrine, I will still supply the school office with a back up auto-injector. **YES NO**

I have received the attached information regarding section 504 eligibility **YES NO**
I wish to be contacted regarding a 504 evaluation **YES NO**

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having severe allergy to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to give the medication(s) as ordered on page 2 of this MAP for allergic reactions and to contact the physician/licensed prescriber for clarification, if needed.

Date _____ Parent/Guardian _____
Signature

☐ If box is checked, **give epinephrine immediately for ANY symptoms if the allergen was likely eaten.**

☐ If box is checked, **give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted**.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
Gut:	Vomiting, crampy pain

1. **Inject Epinephrine Immediately**
2. Call 911
3. Begin monitoring (See "Monitoring" box below)
4. Give additional medication*
   (If ordered)
   -Antihistamine
   -Inhaler

*Antihistamines & inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

Mouth:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **Give Antihistamine**
2. Stay with student; Call parent/guardian
3. If symptoms progress:
   USE EPINEPHRINE (above)
4. Begin monitoring (See below)

Monitoring

Stay with student; call 911and parent/guardian. Tell rescue squad epinephrine was given. Note time epinephrine was given. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For severe reaction, consider keeping student lying on back with legs raised. Keep head to side if vomiting. Treat student even if parents cannot be reached.

See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Epinephrine dose ☐**.15 (junior)** ☐**.3 (adult)** Auto injector brand name if known _____ Two doses are to be made available at school **YES NO**

It is my professional opinion that student should self-carry epinephrine **YES NO**

NOTE: ***If a student is to self carry their epinephrine, help may still be needed to give the medication***.

Antihistamine name _____ **Dosage** (please do not give a range) _____

Other instructions or orders _____

Physician/licensed prescriber name _____

Phone number _____ **FAX number** _____

Signature _____ **Date** _____

Notice of Section 504 Procedural Safeguards

1. Have the District advise you of your rights under federal law;
2. Receive notice with respect to Section 504 identification, evaluation, educational program and/or placement of your child;
3. Have an evaluation, educational and placement decisions made for your child based upon information from a variety of sources and by a team of persons who are knowledgeable about the student, the meaning of evaluation data, and placement options;
4. Have your child receive a free appropriate public education, which is the provision of regular or special education and related aids and services that are designed to meet individual educational needs of your child as adequately as the needs of students without disabilities are met, if your child is Section 504 eligible;. If your child is Section 504 eligible, your child also has the right to have the District make reasonable accommodations to allow your child to an equal opportunity to participate in school and school-related activities;
5. Have your child be educated with non-disabled students to the maximum extent appropriate, if the child is Section 504 eligible;
6. Have your child take part in and receive benefits from the District's education programs without discrimination on the basis of disability;
7. Have your child educated in facilities and receive services comparable to those provided to non-disabled students;
8. Examine all relevant records of your child, including those relating to decisions about your child's Section 504 identification, evaluation, educational program, and placement; and obtain copies of those records at a reasonable cost, unless the fee would effectively deny you access to the records;
9. Receive a response from the District to reasonable requests for explanations and interpretations of your child's records;
10. Receive information in your native language and primary mode of communication;
11. Have a periodic re-evaluation of your child, including an evaluation before any significant change of placement;
12. Have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;
13. Request and participate in an impartial due process hearing regarding the identification, evaluation, or placement of your child, including a right to be represented by counsel in that process and to appeal an adverse decision;
14. File a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office for Civil Rights.