Monona Grove High School 4400 Monona Dr, Monona, WI 53716 608-221-7666 fax: 608-221-7690	Glacial Drumlin School (gr. 6-8) 801 Damascus Tr. Cottage Grove, WI. 53527 608-839-8437 fax: 608-839-8984	Cottage Grove School (gr. 1-2) 470 N. Main St, Cottage Grove, WI 53527 608-839-4576 fax: 608-839-4439
Winnequah School (gr.EC, 4K-5) 800 Greenway Rd. Monona, WI. 53716 608-221-7677 fax: 608-223-6514	Granite Ridge School (gr. 3-5) 4500 Buss Rd. Cottage Grove, WI. 53527 608-839-8980 Fax: 608-839-9345	Taylor Prairie School (EC, 4K-K) 900 N Parkview St, Cottage Grove, WI 53527 608-839-8515 fax: 608-839-8323

Monona Grove School District
Life Threatening Allergy School Emergency Action Plan

Place Student's Picture Here

Student's Name: _____D.O.B. _____ Grade/Teacher _____

ALLERGY TO: _____

Asthmatic? Yes* ☐ No ☐ *Higher risk for severe reaction

If peanut/nut allergic: (check one and have health care provider (HCP) and parent/guardian sign below)

- ☐ This student will sit at a designated peanut/nut free table* in the school cafeteria (*provided for grades K-8).
- ☐ It is not required that this student sit at the peanut/nut free table in the school cafeteria. He/She may sit at the peanut/nut free table if they choose.

SIGNS OF AN ALLERGIC REACTION INCLUDE:

MOUTH: itching, tingling or swelling of the lips, tongue, or mouth
***THROAT:** itching and/or a sense of tightness in the throat, hoarseness, or hacking cough
SKIN: hives, itchy rash, and/or swelling of the face or extremities
GUT: nausea, abdominal cramps, vomiting, and/or diarrhea
***LUNG:** shortness of breath, repetitive coughing, and/or wheezing
***HEART:** very fast "thready" pulse, and/or "passing out"

The severity of symptoms can quickly change! *These symptoms are potentially life threatening

ACTION:

1. ☐ **If ingestion of** _____ is suspected, or ☐ **If stung**, or ☐ **if has above symptoms**
   Give _____ *Medication/dose/route* and _____ *Medication/dose/route* immediately!
   Medications are stored: _____
2. **CALL EMS (911) -** State that an allergic reaction has been treated and additional epinephrine may be needed.
3. **CALL Mother: _____CALL Father_____**
   or emergency contacts: (1)_____**or** (2) _____
4. **CALL Dr. _____ at _____**
5. **DO NOT HESITATE TO ADMINISTER MEDICATION/CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!**

_____ _____ _____ _____
Doctor's signature (required) date Parent/Guardian signature (required) date

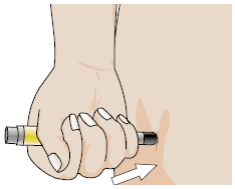
Trained Staff Members

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- Pull off Blue activation cap (pull straight off. Do not twist)

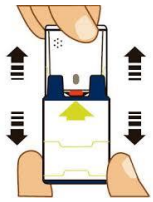
- Hold Orange tip near outer thigh (always apply to outer thigh)



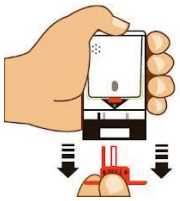
- Sit child down. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Auvi-Q (Epinephrine) Directions

- Pull Auvi-Q from it's outer case. Follow voice prompts.



- Sit child down. When ready to use, pull off RED safety guard.



- Place Black end against middle of OUTER thigh and press firmly (a click is heard). Hold in place for 5 seconds.

Once EpiPen® or Auvi-Q® is used, call the Rescue Squad (911). Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

EPI-PEN®/EPI-PEN JR.®/Auvi-Q® AUTHORIZATION/ RELEASE

Date_____ Birth Date: ____/____/____ Grade_____

Student's Name_____

FOR COMPLETION BY PHYSICIAN

Physician's Name: _____

Telephone Number: _____ Fax Number: _____

Emergency Contact Number: _____

Diagnosis: _____

Name of Medicine: _____Dose: _____

Is the child knowledgeable about his/her Epi-Pen® or Auvi-Q®? ❑ Yes ❑ No

Has the Child demonstrated the proper technique in administering the Epi-Pen®/Auvi-Q®? ❑ Yes ❑ No

Epi-Pen®/Auvi-Q® is administered when needed. Indications:

_____

If needed, how soon can administration of Epi-Pen®/Auvi-Q® be repeated? _____

Side effects: _____

Comments: _____

Please check all that apply:

❑I have instructed the above named student in the proper way to use his/her Epi-Pen®/Auvi-Q®. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself.

❑It is my professional opinion that the above named student should **not carry** and use his/her Epi-Pen®/Auvi-Q® by him/herself. If this box is checked, I authorize school staff to administer the medication named above and understand that the Epi-Pen®/Auvi-Q® will be kept in the school office and will be packed in a backpack to be taken on field trips.

_____ _____ _____

Physician's Signature **Fax Number** **Phone Number**

FOR COMPLETION BY PARENT

We, the parent/guardian of the above named student, request that assistance be provided to my child in taking the medicine(s) indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself**. My child knows he/she must inform school personnel if he/she self-medicates.** Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

We, the parent/guardian of the above named student authorize permission for him/her to carry the medication on his/her person or keep same in his/her locker as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of his/her Epi-Pen®/Auvi-Q® ❑ **Yes** ❑ **No**

The school office has been provided with a back-up Epi-Pen®/Auvi-Q®: ❑ **Yes** ❑ **No**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Work Phone: _____Home Phone: _____ Oct. 2013 LH form available at www.mononagrove.org