

Phoenix Union High School District  
**ALLERGIES AND ANAPHYLAXIS HEALTH CARE ACTION PLAN AND PHYSICIAN ORDERS**  
**PLAN DE ACCIÓN DE ATENCIÓN MÉDICA DE ALERGIAS Y ANAFILAXIS Y PEDIDOS MÉDICOS**

School Year (Año Escolar): \_\_\_\_\_ Grade (Grado): \_\_\_\_\_ Date of Birth (Fecha de Nacimiento): \_\_\_\_\_

Student Name (Nombre de Alumno): \_\_\_\_\_ Student ID #: \_\_\_\_\_

Parent/Guardian Name (Nombre de Padre/Madre/Tutor): \_\_\_\_\_

Cell Phone (Teléfono Celular): \_\_\_\_\_ Work (Trabajo): \_\_\_\_\_ Home (Casa): \_\_\_\_\_

Physician (Nombre del Medico): \_\_\_\_\_ Phone (Teléfono): \_\_\_\_\_

The parent/guardian agree and understand that they are responsible for maintenance of equipment, furnishing all equipment, medications, and supplies necessary in providing services to the student during school hours. The parent/guardian is also responsible for notifying the school nurse anytime there is a change in orders, medications, and/or in the student's medical condition.

I give permission for the school to allow my child to self-carry and self-administer prescribed medications during school hours and if assistance is necessary, allow authorized trained school personnel to administer medications and perform medical procedures as ordered by the physician/healthcare provider licensed in Arizona. I authorize the school to contact my child's physician/healthcare providers and/or dispensing pharmacies, should any questions, any additional orders and/or necessary documents be required for the care of my child during school hours.

El padre / tutor acuerda y entiende que es responsable del mantenimiento del equipo, el suministro de todo el equipo, los medicamentos y los suministros necesarios para proporcionar servicios al alumno durante el horario escolar. El padre / tutor también es responsable de notificar a la enfermera de la escuela cada vez que haya un cambio en las órdenes, medicamentos y / o en la condición médica del estudiante.

Doy permiso para que la escuela permita que mi hijo lleve consigo y autoadministre los medicamentos recetados durante el horario escolar y, si es necesaria, permita que el personal autorizado de la escuela administre los medicamentos y realice los procedimientos médicos según lo ordenado por el médico o proveedor de servicios de salud con licencia en Arizona. Autorizo a la escuela a ponerse en contacto con el médico de mi hijo / proveedores de atención médica y / o farmacias de entrega, en caso de tener preguntas, pedidos adicionales y / o documentos necesarios para el cuidado de mi hijo durante el horario escolar.

\_\_\_\_\_  
Parent/Guardian Signature (Firma de Padre/Madre/Tutor) \_\_\_\_\_  
Date (Fecha)

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**FOR LICENSED PHYSICIAN/HEALTHCARE PROVIDER USE ONLY - PLEASE WRITE LEGIBLY**

**THE PHOENIX UNION HIGH SCHOOL DISTRICT IS REQUESTING YOUR ASSISTANCE IN COMPLETING THIS TWO-PAGE FORM TO IDENTIFY ANY SERVICES THAT WE MAY NEED TO PROVIDE TO THE STUDENT IN THE SCHOOL SETTING.**

Students who have been diagnosed with anaphylaxis may carry and self-administer emergency medications including auto-injectable epinephrine provided the student's name is on the prescription label, on the medication container or device and annual written documentation from the student's parent or guardian is provided that authorizes possession and self-administration. OTC medications (including vitamins) must be brought to school by the parent/guardian in the original container with all warnings and directions intact.

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**PLAN DE ACCIÓN DE ATENCIÓN MÉDICA DE ALERGIAS Y ANAFILAXIS Y PEDIDOS MÉDICOS**

Student Name: \_\_\_\_\_ School Year: \_\_\_\_\_

**STUDENT MEDICAL DIAGNOSIS:** \_\_\_\_\_  
\_\_\_\_\_

**STUDENT FOOD AND DRUG ALLERGIES**

- |  |   |
|--|---|
| <input type="checkbox"/> Soy                       | <input type="checkbox"/> Wheat  |
| <input type="checkbox"/> Shellfish/fish            | <input type="checkbox"/> Milk   |
| <input type="checkbox"/> Nuts (tree nuts, peanuts) | <input type="checkbox"/> Eggs   |
| <input type="checkbox"/> Strawberry/berries        | <input type="checkbox"/> Pollens/dust/mold/strong odors such as perfume |
| <input type="checkbox"/> Animal hair (cat, dog)    | <input type="checkbox"/> Clothing/carpet                                |
| <input type="checkbox"/> Iodine                    |   |
| <input type="checkbox"/> Other: _____              |   |

Student can present with the following reactions: \_\_\_\_\_

**MEDICATION ADMINISTRATION AND PHYSICIAN ORDERS**

**SEE MEDICAL DOCUMENTS/ORDERS ATTACHED**

Must include name of medication, dose, route, administration time, or as needed. Medications brought to the school by the parent/guardian must be in the original labeled container dispensed by the pharmacy and must include a current pharmacy label with physician instructions and student's name.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ADDITIONAL SPECIAL INSTRUCTIONS/PHYSICIAN ORDERS**

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN OR HEALTHCARE PROVIDER SIGNATURE REQUIRED BY THE SCHOOL**

A school nurse is NOT always available on the school campus but trains authorized unlicensed assisted personnel (UAP) to care for ill and injured students, administer medications as ordered by the physician/healthcare provider and perform first aid rescue measures as needed.

Student has been instructed and is **ALLOWED** to self-carry appropriate medications, monitoring equipment, and self-administer medications prescribed for the care of allergic reaction/anaphylaxis. The student is be able to practice proper safety precautions for the handling and disposal of the equipment and medications that the student is authorized to use. Student misuse of medication being self-administered may result in seizure of medications and disciplinary action by the school.

Student is **NOT ALLOWED** to self-carry, use and self-administer medication/s and will require assistance by authorized trained school personnel.

Physician/Healthcare Provider Printed Name: \_\_\_\_\_

Physician/ Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Reviewed by School Nurse Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_