School Year _____

Student's Name_____

Date of Birth_____ Age _____

Student Photo Here

This MAP is to be completed, signed and dated by a parent/guardian and the treating physician or licensed prescriber. Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medications and any other needed equipment/supplies to the school.

Contact Information

Call First	**Try Second**
Name:_____	Name: _____
Relationship:_____	Relationship: _____
Home Phone:_____	Home Phone: _____
Cell:_____	Cell: _____
Work:_____	Work: _____

Call Third (If a parent /guardian cannot be reached)

Name: _____

Relationship:_____Phone: _____

Allergy History

Allergy to:_____

Asthma ☐ Yes (higher risk for severe reaction) ☐ No

_____

Past response to allergen included:_____

_____

Other related medical conditions:_____

Student wears medical alert jewelry □Yes □No

Student knows what foods/triggers to avoid □Yes □No

Student asks about food ingredients □Yes □No

Student reads and understands food labels □Yes □No

Student tells an adult immediately after an exposure □Yes □No

Student identifies symptoms of an allergic response □Yes □No

Student self-carries emergency medication (requires healthcare provider order) □Yes □No

Student knows how to use emergency medication □Yes □No

Current Section 504 Plan □Yes □No

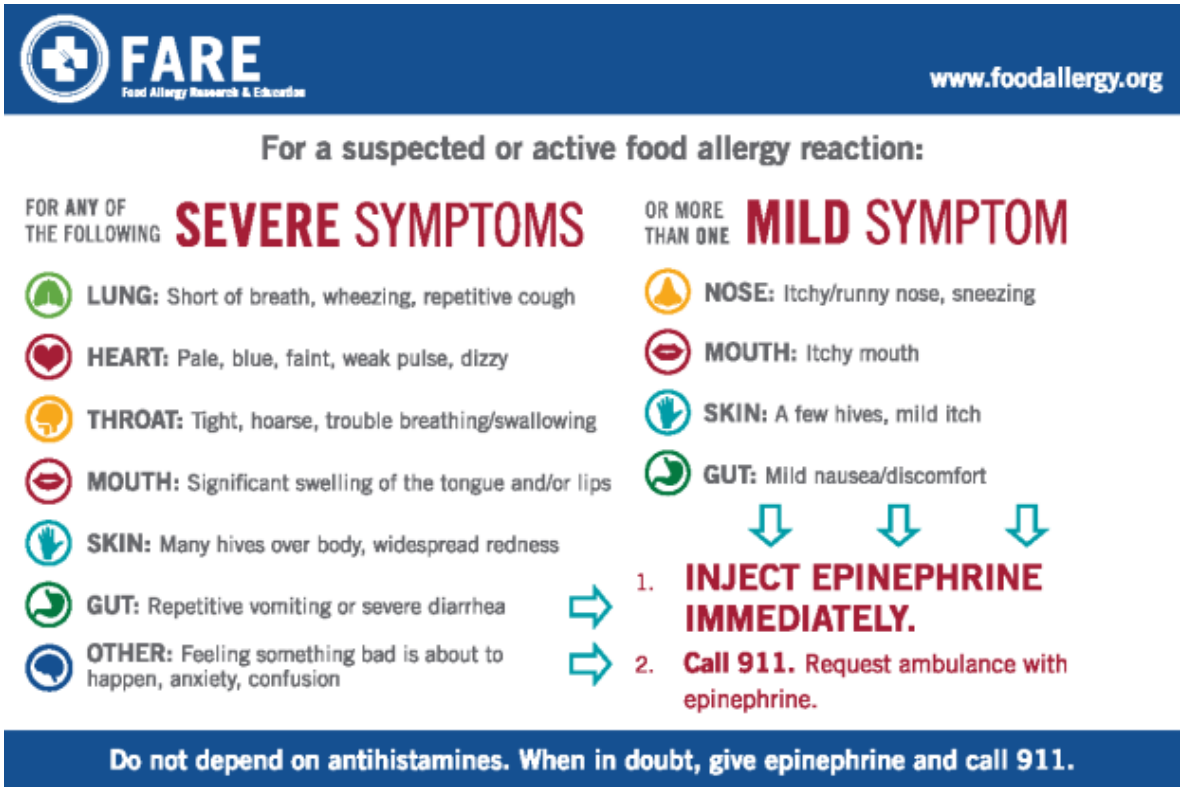
Other instructions_____

_____

I agree to have the information in this plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having allergies to better identify needs. 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 administer any medication ordered for the Allergy Medical Action Plan and to contact the ordering physician/licensed prescriber for clarification of this plan if needed.

Parent/Guardian Signature_____Date_____

Allergy Action Plan:



Monitoring: Stay with student. Tell rescue squad epinephrine was given. A second dose of epinephrine an be given five minutes of more after the first if symptoms persist or recur. Treat student even if parents cannot be reached.

Physician/Licensed Prescriber Order & Agreement with Protocol

This section must be completed by the Physician or Licensed Prescriber

☐ **Name of Medication:**_____

Dose:_____

Frequency:_____

Time to be given:_____

Other instructions:_____

☐ **Name of Medication:**_____

Dose:_____

Frequency:_____

Time to be given:_____

Other instructions:_____

Physician/Licensed Prescriber's Name_____

Phone number_____**Fax number**_____

Physician's Signature_____**Date**_____

Parental Permission

It is my understanding that Ivywood Classical Academy has taken every precaution to safeguard my child. I release and agree to hold the Academy, its Board members, staff working at the Academy, volunteers, and agents harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from the administration of the medication/treatment.

I also agree to defend, indemnify, and hold harmless the Academy, its Board members, staff working at the Academy, volunteers and agents from and against any such claims, demands, suits, damages, liability, costs, and expenses (including reasonable attorney fees) incurred as a consequence either directly or indirectly of the granting of this authorization to administer the medication/treatment.

I request that school staff give my child the above medication as ordered. I give permission for the prescriber to be contacted by school staff about this order if clarification is needed.

Parent/Guardian_____Date_____
Signature

Phone Number_____Alternate number_____

Medication should be in the original labeled container. It is the parent/guardian's responsibility to: replace expired medication; provide refills when needed; transport the medication to & from the school office; and pick it up at the end of the school year. The school does not store medicine over the summer.