LEXINGTON CHRISTIAN ACADEMY

ALLERGY and/or EPINEPHRINE ACTION PLAN 2025-2026 SCHOOL YEAR

A parent/guardian and the student's primary care physician (PCP) must complete this form to authorize Lexington Christian Academy (LCA) personnel to treat the student. Parents must update the form prior to each year the student is attending LCA. For your reference, LCA's Medical Guidelines can be found on the back of the Allergy and/or Epinephrine Action Plan.

STUDENT & PARENT/GUARDIAN INFORMATION

Name: _____

Grade Level: _____ Date of Birth: _____

Parents/Guardian Name: _____

Cell Phone (mom): _____ Cell Phone (dad): _____

Emergency Contact: _____ Cell Phone: _____

MEDICAL INFORMATION (TO BE COMPLETED BY PHYSICIAN)

ALLERGIC TO: _____

PAST REACTION/IDENTIFYING SYMPTOMS: _____

ASTHMA: _____ YES _____ NO

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **USE EPINEPHRINE**.

Anaphylaxis reaction to: _____

THEREFORE:

_____ If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, even if no symptoms appear.
_____ If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms appear.
_____ If checked, give epinephrine immediately for any symptoms, even if not eaten.

MEDICATIONS

Epinephrine Brand or Generic: _____

Epinephrine Dose: ___ 0.15 mg IM ___ 0.3 mg IM Other (e.g., inhaler-bronchodilator if wheezing):

Oral Antihistamine Brand or Generic: _____ Oral Antihistamine Dose: _____

Inhaler-bronchodilator: _____ Inhaler-bronchodilator Dose: _____

___ **IF CHECKED STUDENT WILL SELF-CARRY EPI PEN**. This student is capable and has been instructed in the proper method of self-administering medications named above. All students are encouraged to provide an additional EpiPen to LCA.

Location of back-up EpiPen: _____

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TREATMENT PLAN:

Epinephrine will be administered for any or a combination of the following severe symptoms:

LUNG
Shortness of Breath, wheezing, Repetitive cough

HEART
Pale or bluish skin fainting, weak pulse, or dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant Swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, or confusion

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **CALL 911**. Tell emergency dispatcher the person is having anaphylaxis and may need Epinephrine when emergency responders arrive.
   *If ordered above, administer Antihistamine OR inhaler (bronchodilator) if student is wheezing
   *Lay the student flat, raise legs, and keep warm. If breathing is difficulty or they are vomiting, let them sit up or lie on their side.
   *If symptoms do not improve, or symptoms return, administer a 2nd dose of epinephrine about 5 minutes or more after the last dose.
   *Contact parent/guardian and/or emergency contacts.
   *Transport student by EMS to the nearest Emergency Room or dismiss student to parent so that they can be taken home.

For any or a combination of the following mild symptoms:

NOSE
Itchy or runny nose

MOUTH
Itchy mouth

SKIN
A few hives mild itch

GUT
Mild nausea or discomfort

For **MILD SYMPTOMS** from more than one symptom area: give epinephrine.

For **MILD SYMPTOMS** from **A SINGLE SYMPTOM** area, follow the directions below:
1) Antihistamines may be given, if ordered by a health care provider.
2) Stay with the person, alert emergency contacts.
3) Watch closely for changes. If symptoms worsen, given epinephrine.
4) Contact EMS if Epinephrine has been administered.

Physician's Name: _____

Physician's Signature: _____ **Date:** _____

ALL MEDICATION WILL BE DISCARED IF NOT PICKED UP BY MAY 31, 2026. THE ABOVE MEDICATION ORDER IS VALID FOR ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without it. Whenever possible, administration of medication should be done at home. (Medication prescribed three times per day can be given before school, after school, and at bedtime.) If a new medication is started, the first dose must be given at home, unless it is a rescue medication.

The school will adhere to the following guidelines as it pertains to medication:

1) Administration of prescription medication by school personnel must only be done according to the written order of a licensed prescriber and written authorization of parent / guardian and Licensed School Nurse, regardless of the student's age.

- Mixed dosages in a single container will not be accepted for administration at school.
- If a half tablet is required for a correct dosage, it is the parent's / guardian's responsibility to provide pre-cut tablets for administration at school.
- Altered forms of medication will not be accepted or administered at school.
- Narcotics / medical cannabis will not be administered at school.
- Aspirin-containing products will not be administered at school.

2) All medication (prescription and non-prescription) must be brought to and from school by a parent / guardian in its original container. The following information must be on the prescribed container label:

- Student's full name
- Name and dosage of medication
- Time and directions for administration at school
- Physician / licensed prescriber's name
- Date (must be current)

3) New consent forms from a health care provider and parent / guardian signatures must be received each school year.

4) A new medication consent form is required when the medication dosage or time of administration is changed.

5) When a long-term daily medication is stopped, a written physician / licensed prescriber's order is requested.

6) In preschool this allergy sheet will be displayed in the classroom inside a cabinet for easy reference in the case of an emergency.

INFORMATION TO BE COMPLETED BY PARENT/GUARDIAN

- I have read and agree with the school's medication guidelines as listed on the back of the allergy and/or epinephrine action plan form.
- I give permission for the medication to be given by designated personnel as delegated, trained, and supervised by the Licensed School Nurse.
- I authorize the Licensed School Nurse or designee to exchange information with my child's healthcare provider concerning any questions that arise regarding the listed medication, medical condition, or side effects of this medication
- I authorize the Licensed School Nurse or designee to communicate with appropriate school personnel regarding this medication for my child
- I release school personnel from any liability in relation to the administration of this medication to the school.
- I will add the medication to the student's FACTS Family medication list.

PARENT NAME: _____ **PARENT SIGNATURE:** _____ **DATE:** _____