School Year 2024-2025

Student Name_____ Attachment B

Madison District Public School

SEVERE ALLERGY Medical Action Plan (MAP)

Child's picture
Face only

Student's Name _____
Date of birth_____ **School** _____
Age _____ **Grade**_____ **Teacher**_____

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.
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Bus # Driver: Route # Medical File

Transportation Office Use ONLY if needed

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 **or** FORM A for prescribed medication at school (you do not need to do both)

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

☐**YES** ☐**NO I request that my child sit at a no peanut or tree nut table for lunch.**

Other foods to avoid _____
List of Different SEVERE ALLERGIES (such as, Insect stings and Latex)

☐**YES** ☐**NO** I would like to talk with the school nurse coordinator about my child's allergies
☐**YES** ☐**NO** If my child is to self-carry epinephrine, I will still supply the school with a back up auto-injector.
☐**YES** ☐**NO** I would like epinephrine auto injectors kept in more than one school location
☐**YES** ☐**NO** I have read the attached information regarding section 504 eligibility
☐**YES** ☐**NO** I wish to be contacted regarding a 504 evaluation

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. 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 of orders, if needed.

Date_____ Parent/Guardian_____
Signature

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

□ If 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 staff that epinephrine was given and the time of administration. 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.

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan (see page 1)

Epinephrine dose □**.15 (junior)** □**.3 (adult)**
□ **YES** □ **NO** Two doses are to be made available at school

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

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) _____
(note, liquid is faster acting than a pill form)
Other instructions or orders_____

Physician/licensed prescriber name (Print)_____

Phone number_____**FAX number** _____

Signature_____**Date**_____

See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area. Directions for use are also printed on the medication. Check the expiration date when an Auto-injector is brought to school.

***For Office Use*: Epinephrine will expire this school year** □ **NO** □**YES (if yes, when)** _____
***For Office Use*: Location(s) of auto-injector (epinephrine) in the school** _____

MADISON
DISTRICT PUBLIC SCHOOLS
Serving Families One Student at a Time

NOTICE OF SECTION 504 PROCEDURAL SAFEGUARDS FORM C

The following is a brief summary description of the rights provided by Section 504 of the Rehabilitation Act of 1973 to students with disabilities, or suspected disabilities, and some related rights provided by Title VI of the Civil Rights Act of 1964 and the Family Educational Rights and Privacy Act. The intent of the law is to keep you fully informed about decisions concerning your child and to inform you of your rights in the event you disagree with any decisions concerning your child. You have the right to:

1. have the District advise you of your rights under federal law;

2. receive notice with respect to Section 504 identification, evaluation, and/or placement of your child

3. have an evaluation and placement decision for your child based upon information from a variety of sources and which is made by a team of persons 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 the child is Section 504 eligible;

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 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 information in your native language and primary mode of communication;

I 0. have a periodic re-evaluation of your child, including an evaluation before any significant change of placement;

1 1. have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;

12. 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;

13. file a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office for Civil Rights.