Anchorage School District

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

*Having asthma increases the risk of having a more severe allergic reaction.

(If this student is not able to self-treat, a nurse or trained adult may administer Epinephrine auto injector)

Hives	Scratchy throat	Itching	Rash	Nasal Congestion	Watery or itchy eyes
Abdominal pain or cramping		Pain or tightness in the chest		Diarrhea	Wheezing or coughing
Swelling of the eyes, face, or tongue		Heart palpitations or racing		Dizziness	Nausea or vomiting
Difficulty swallowing or talking		Sense of impending doom		Unconsciousness	Shortness of breath

Other ______________________________

I request that the medication(s) selected and allergy/anaphylaxis protocols listed on this plan be provided to my child. I understand that, in the absence of the nurse, other trained Anchorage School District ("ASD") personnel may administer this medication.

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for