MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

School District School: FAX:

Student:_____ Birth Date:_____ Grade:_____

Parent Section *Seccion des Padres*

I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions. *Yo pido que la enfermera o personal designado le adminstre el medicamento recetado de acuerdo con las instrucciones del medico.*

I give my permission for the medication information to be shared with school staff on a "need to know basis." ☐ Yes/*si* ☐ No
Doy permiso que la siguiente informacion sea compartida con el personal escolar que necesite estar informado

I give permission for my child to carry this emergency medication. ☐ Yes/*si* ☐ No
Doy permiso para que mi estudiante pueda cargar su medicamento de emergencia

I give permission for my child to self-administer this emergency medication. ☐ Yes/*si* ☐ No
Doy permiso para que mi estudiante pueda administrarse su propio medicamento de emergencia

_____ _____ _____ _____
Signature/Firma *Date/Fecha* *Phone #1 Numeros de telefoonas* *Phone #2*

LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW

Student has severe allergy to: _____

Describe symptoms in previous reactions: _____

_____

Student also has asthma? ☐ No ☐ Yes (Together they increase adverse outcome risk)

Complete Box 1 (required for all students) and if appropriate, Box 2.

☐ 1) Treatment for Exposure to Allergen/Suspected Exposure OR Serious Symptoms

Exposure/Suspected Exposure OR Serious Symptoms:	1. **Give Epinephrine IM Immediately**
Skin: hives, swelling in areas other than allergen contact area. Mouth: itching, swelling of lips, tongue or mouth. Throat: itching, sense of tightness, hoarseness,. Lungs: significant shortness of breath, repetitive coughing, wheezing. Gut: nausea, cramps, vomiting, and/or diarrhea. Heart: lightheadedness; dizziness; passing out	☐ Epinephrine auto-injector 0.15mg ☐ Epinephrine auto-injector 0.3mg If symptoms continue, repeat Epinephrine after _____ minutes. *(If repeat dose ordered, please provide school with 2nd dose.)* 2. Note time given. 3. Call 911. Ask for Advanced Life Support for an allergic reaction. 4. Call parent/guardian. 5. Remain with student until EMS arrives.

☐ 2) Optional Treatment for No Known Exposure WITH Mild Symptoms

No Known Exposure WITH Mild Symptoms (please check):	☐ Notify parent/guardian to pick up student for observation. **OR** ☐ 1. Give Antihistamine. (Specify medication/dose/frequency) _____ 2. Notify parent/guardian antihistamine has been given and to pick student up for further observation. **If serious symptoms develop, give Epinephrine as instructed in Box 1 above.**
☐ Localized hives ☐ Localized swelling ☐ Other (describe)_____ _____ _____	

This student may carry this emergency medication at school. ☐ Yes ☐ No

This student is trained and capable to self-administer this emergency medication. ☐ Yes ☐ No

Medication order is valid for duration of current school year (which includes summer school).

_____ _____
Licensed Health Care Provider Signature *Printed LHCP Name*

_____ _____ _____
Date *Health care provider phone* *Health care provider FAX*