MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

School District Toppenish School:_____ FAX: (509) 865-2178

Student:_____ Birth Date:_____ Grade:_____

Parent Section *Sección de Padres*

I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provi instructions. I understand that this information will be shared with school staff on a "need to know" basis.

Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del médico. Yo entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.

I give permission for my child to carry this medication. ☐ Yes/ *Sí* ☐ No
Doy permiso para que mi hijo/hija pueda cargar su medicamento.

I give permission for my child to self-administer this medication. ☐ Yes/ *Sí* ☐ No
Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.

I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) ☐ Yes/*Sí* ☐ No
Doy permiso para la enfermera de iniciar un plan 504. (Ver formulario adjunto)

_____ _____ _____ _____
Signature/Firma *Date/Fecha* *Phone #1* *Números de teléfonos* *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

If yes, rescue inhaler may be used **after** the Epinephrine has been given: ☐ Yes ☐ No

REQUIRED SECTION

Treatment for *Exposure to Allergen/Suspected Exposure OR Serious Symptoms*

Exposure/Suspected Exposure
OR
Serious Symptoms:

- Hives or swelling in areas other than allergen contact area
- Itching, swelling of lips, tongue, throat , or mouth
- Sense of tightness in throat, hoarseness
- Significant shortness of breath, repetitive coughing, wheezing
- Nausea, cramps, vomiting, and/or diarrhea
- Lightheadedness; dizziness; passing out

1. **Give Epinephrine IM Immediately** *(side effects: ↑ HR, nervousness)*
   Epinephrine auto-injector: ☐ 0.15mg OR ☐ 0.3mg
   ☐ If symptoms continue, repeat Epinephrine after 5 - 10 minutes.
   (If repeat dose ordered, please provide school with 2nd dose.)
   Optional:
   ☐ **After** giving epinephrine, give ____mg antihistamine
   *specify medication:*_____
2. Note time given
3. **Call 911**, ask for Advanced Life Support for an allergic reaction
4. Call School Nurse (if available) and notify parent/guardian
5. Remain with student until EMS arrives. Student should be lying down

OPTIONAL SECTION

Treatment for *No Known/Suspected Exposure to Life-Threatening Allergen WITH ONLY Mild Symptoms*

No Known or Suspected Exposure to Life-Threatening Allergen and ONLY

☐ A few localized hives
☐ Other:_____
_____

Common side effects of antihistamine include drowsiness, dry mouth and constipation.

☐ Notify parent/guardian to pick up student for observation

OR

☐ 1. Give _____ mg antihistamine
*specify medication:*_____

2. Notify parent/guardian that antihistamine was given and to pick student up for further observation.

☐ **If a serious symptom develops, give Epinephrine as instructed above.**

This student may carry this emergency medication at school and on the bus ☐ 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*

May, 2015