

MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

School District: **Wilson Creek School District**

School: _____

FAX: 509-345-2288

Student: _____ Birth Date: _____ Grade: _____

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|--------------------------------------|--|----------|----------------------|----------|
| 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. <i>Yo pido que la enfermera o personal designado le adminstre el medicamento recetado de acuerdo con las instrucciones del medico.</i> | | | |
| | I give my permission for the medication information to be shared with school staff on a "need to know basis." <input type="checkbox"/> Yes/si <input type="checkbox"/> No <i>Doy permiso que la siguiente informacion sea compartida con el personal escolar que necesite estar informado</i> | | | |
| | I give permission for my child to carry this emergency medication. <input type="checkbox"/> Yes/si <input type="checkbox"/> No <i>Doy permiso para que mi estudiante pueda cargar su medicamento de emergencia</i> | | | |
| | I give permission for my child to self-administer this emergency medication. <input type="checkbox"/> Yes/si <input type="checkbox"/> No <i>Doy permiso para que mi estudiante pueda administrarse su propio medicamento de emergencia</i> | | | |
| _____ | _____ | _____ | _____ | _____ |
| Signature/Firma | Date/Fecha | Phone #1 | Numeros de telefonos | 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

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| <p>Exposure/Suspected Exposure OR Serious Symptoms:</p> <p><u>Skin:</u> hives, swelling in areas other than allergen contact area. <u>Mouth:</u> itching, swelling of lips, tongue or mouth. <u>Throat:</u> itching, sense of tightness, hoarseness,. <u>Lungs:</u> significant shortness of breath, repetitive coughing, wheezing. <u>Gut:</u> nausea, cramps, vomiting, and/or diarrhea. <u>Heart:</u> lightheadedness; dizziness; passing out</p> | <p>1. Give Epinephrine IM Immediately</p> <p><input type="checkbox"/> Epinephrine auto-injector 0.15mg <input type="checkbox"/> Epinephrine auto-injector 0.3mg</p> <p>If symptoms continue, repeat Epinephrine after _____ minutes. <i>(If repeat dose ordered, please provide school with 2nd dose.)</i></p> <p>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.</p> |
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2) Optional Treatment for No Known Exposure WITH Mild Symptoms

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| <p>No Known Exposure WITH Mild Symptoms (please check):</p> <p><input type="checkbox"/> Localized hives <input type="checkbox"/> Localized swelling <input type="checkbox"/> Other (describe) _____ _____ _____</p> | <p><input type="checkbox"/> Notify parent/guardian to pick up student for observation.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> 1. Give Antihistamine. (Specify medication/dose/frequency) _____</p> <p>2. Notify parent/guardian antihistamine has been given and to pick student up for further observation.</p> <p style="text-align: center;">If serious symptoms develop, give Epinephrine as instructed in Box 1 above.</p> |
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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