MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

School District: Entiat FAX:509-784-2986 School: Student: Birth Date: Grade: 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 Parent Section Seccion des Padres 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 1. Give Epinephrine IM Immediately ☐ Epinephrine auto-injector 0.15mg Serious Symptoms: Epinephrine auto-injector 0.3mg Skin: hives, swelling in areas other than allergen contact area. If symptoms continue, repeat Epinephrine after minutes. Mouth: itching, swelling of lips, tongue or (If repeat dose ordered, please provide school with 2^{nd} dose.) mouth. Throat: itching, sense of tightness, 2. Note time given. hoarseness,. Lungs: significant shortness of breath, 3. Call 911. Ask for Advanced Life Support for an allergic reaction. repetitive coughing, wheezing. Gut: nausea, cramps, vomiting, and/or 4. Call parent/guardian. diarrhea. Heart: lightheadedness; dizziness; 5. Remain with student until EMS arrives. passing out 2) Optional Treatment for No Known Exposure WITH Mild Symptoms No Known Exposure Notify parent/guardian to pick up student for observation. WITH OR Mild Symptoms (please check): 1. Give Antihistamine. (Specify medication/dose/frequency) Localized hives Localized swelling Other (describe) 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. This student may carry this emergency medication at school. Yes No This student is trained and capable to self-administer this emergency medication. Yes Πo 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

ESD 105 & 171

Anaphylaxis Form March 2010