MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL
AUTORIZACIÓN MÉDICA PARA MANEJO DE ALERGIA SEVERA EN LA ESCUELA

Student/Estudiante: ______________________________ Birthdate/Fecha de Nacimiento: ___________ Grade/Grado: _____

Nurse/Enfermera(o): _______________ Phone/Teléfono: ___________ School/Escuela: _____________ FAX: ____________

Parent Section / ***Sección de los padres***

I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions. By signing below I authorize that medical information pertaining to Severe Allergies and use of the following medications be exchanged with my student's school nurse in written and verbal forms. I further give permission for these orders to be faxed to the school. *Yo pido que la enfermera o personal designado administre el siguiente medicamento recetado de acuerdo con las instrucciones del médico. Al firmar abajo doy autorización para que la información médica pertinente a Alergias Severas y al uso de los siguientes medicamentos sea comunicada con la enfermera de la escuela de mi estudiante en forma verbal y escrita. También doy permiso para que estas órdenes se envíen por fax a la escuela.*

I give permission for my child to self-administer and carry this medication. ☐ Yes/*Si* ☐ No
Doy permiso para que mi hijo se administre y cargue este medicamento.

I give permission for the nurse to initiate an Emergency Care Plan/504 Plan. ☐ Yes/*Si* ☐ No
Doy permiso para que la enfermera inicie un plan de cuidado de emergencia/plan 504.

Signature/Firma *Date/Fecha* *Phone #1* *Números de teléfonos* *Phone #2*

Student has severe allergy to/*El estudiante tiene alergia severa a:* ______________________________

Describe symptoms in previous reactions/*Describa los síntomas en reacciones previas*: ______________________

_ _ _ _ _ _ _ _ _ _ LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW _ _ _ _ _ _ _ _ _ _ _

_ _ _ EL PROVEEDOR DE SERVICIOS DE SALUD AUTORIZADO DEBE COMPLETAR LA SECCIÓN DE ABAJO _ _ _

Student also has asthma? ☐ No ☐ Yes (Asthma Management Form Needed Also)

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

REQUIRED 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 With Nurse On Site: Treatment for No Known Exposure WITH Mild Symptoms

No Known Exposure WITH Mild Symptoms (please check):	
☐ A few hives ☐ Other (describe)______________ ______________________ *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 serious symptoms develop, give Epinephrine as instructed above.**

Recommend student self-administer and carry this emergency medication at school. ☐ Yes ☐ No

Recommend Medication on bus. **If yes, Student will need two epi's for school** ☐ Yes ☐ No

Medication order is valid for duration of school year____________ (includes summer school).

______________________________ ______________________
Licensed Health Care Provider Signature *Printed LHCP Name*

______________________ ______________________ ______________________
Date *Health care provider phone* *Health care provider FAX*

*Approval to self carry: Nurse*______________________________ *Principal*______________________________