HIGHLAND SCHOOL DISTRICT 203

MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

SCHOOL: _____ **YEAR:** _____

STUDENT: _____ **DOB:** _____ **AGE:** _____

GRADE: _____ **PARENT/GUARDIAN** (PRINT): _____

PARENT/GUARDIAN SECTION SECCIÓN DE PADRE/GUARDIAN

I request the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare instructions. *Solicito a la enfermera de la escuela, o al miembro del personal designado, que administre el medicamento prescrito a continuación, de acuerdo con las instrucciones de atención médica.*

I give permission for the following medication information to be shared with school staff on a "need to know" basis. ☐ Yes ☐ No
Doy permiso para que la siguiente información sobre medicamentos se comparta con el personal de la escuela según la "necesidad de saber".

I give permission for my child to carry this emergency medication. ☐ Yes ☐ No
Doy permiso para que mi hijo/hija lleve este medicamento de emergencia.

I give permission for my child to self-administer this medication. ☐ Yes ☐ No
Doy permiso para que mi hijo/hija se auto administré este medicamento.

_____	_____	_____/_____	
Parent/Guardian Signature Firma de Padre/Guardian	Date Fecha	Home Phone Teléfono de Casa	Emergency phone Teléfono de Emergencia

- - - - - - - - - - LICENSED HEALTHCARE PROVIDER TO COMPLETE SECTIONS 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 Allergens/Suspected Exposure OR Serious Symptoms

Exposure/Suspected Exposure OR
Serious Symptoms:

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.

1. **Give Epinephrine IM immediately**
   - ☐ Epinephrine auto-injector 0.15 mg
   - ☐ Epinephrine auto-injector 0.3 mg

   If symptoms continue, repeat Epinephrine after _____ minutes.
   (If repeat dose ordered, please provide school with 2nd dose.)
2. Notes 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):

☐ Localized hives
☐ Localized swelling
☐ Other (describe) _____
_____
_____

☐ Notify parent/guardian to pick up student for observation
OR
☐ 1. Give Antihistamine: (Specify medication/dose/route/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.

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*