



ANAPHYLAXIS MEDICATION AUTHORIZATION

(Must be completed by parent/legal guardian and physician before medication can be accepted at school)

SCHOOL YEAR: _____

STUDENT NAME: _____ Date of Birth: _____

PARENT/LEGAL GUARDIAN: _____

PHONE #1: _____ PHONE #2: _____

EMERGENCY CONTACTS: _____

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE #: _____

CHILD IS SEVERELY ALLERGIC TO: _____

MEDICATION TO BE ADMINISTERED AT SCHOOL:

MEDICATION	DOSE
DIPHENHYDRAMINE	
EPINEPHRINE	<input type="checkbox"/> 0.15 MG <input type="checkbox"/> 0.30 MG
OTHER	

PHYSICIAN'S SPECIFIC INSTRUCTIONS FOR MEDICATION ADMINISTRATION:

STUDENT MUST CARRY MEDICATION: YES NO STUDENT IS ASTHMATIC: YES NO

STUDENT IS AT HIGH RISK FOR SEVERE REACTION: YES NO

STUDENT IS REQUIRED TO CARRY THIS MEDICATION ON THE BUS: YES NO

CHILD'S FIRST SYMPTOMS MAY START AS: (CHECK ALL THAT APPLY)

Itching and swelling of the lips, tongue, or mouth

Hives, itchy rash, and/or swelling around the face or extremities

Shortness of breath, repetitive coughing, and/or wheezing

Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough

Nausea, abdominal cramps, vomiting, and/or diarrhea

"Thready" pulse or passing out



STUDENT NAME: _____

THE SCHOOL DISTRICT WILL PROVIDE TRAINING FOR STAFF AT THE SCHOOL TO ASSIST YOUR CHILD IF NEEDED.

FIELD TRIPS:

I will accompany my child on all field trips away from the school and assume responsibility for administering medication if needed.

The student has permission from the physician to carry and self-administer the medication and will be responsible for having medication available for trips off campus.

The teacher in charge of the field trip will additionally be trained and have responsibility for administering medication if needed.

BUS TRANSPORTATION:

YES, THE BUS DRIVER NEEDS TO BE NOTIFIED NO, THE BUS DRIVER DOES NOT NEED TO BE NOTIFIED

PARENT/LEGAL GUARDIAN WILL PROVIDE ALL NECESSARY SUPPLIES/MEDICATION AND NOTIFY THE SCHOOL OF CHANGES IN CONDITION OR PRESCRIBED TREATMENT PLAN

I understand that all medication will be provided by me in the original container, clearly labeled with prescription information that lists my child's name. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. I give the school permission to contact listed physician's office to request medical information concerning my child. I am aware of the expiration date and will replace medication before it expires. If the physician authorizes my child to carry his/her medication during the school day, I understand that I cannot hold the school district responsible for any adverse outcome of this action.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

*I HAVE SEEN THIS CHILD AND AGREE **WITH THE ABOVE TREATMENT:***

PHYSICIAN'S SIGNATURE: _____ DATE: _____

BOTH AREAS MUST BE COMPLETED IF THE MEDICATION IS TO BE CARRIED AND SELF-ADMINSTERED

0 THIS STUDENT IS TO SELF-ADMINISTER AND SELF-MONITOR THIS MEDICATION WHILE AT SCHOOL. TRAINING HAS BEEN COMPLETED BY THE PHYSICIAN AND THE STUDENT HAS DEMONSTRATED COMPETENCY IN SELF-MONITORING AND SELF-ADMINISTRATION OF THIS MEDICATION. MEDICATION MUST BE WITH STUDENT DURING CLASSTIME AND ANY SCHOOL SPONSORED ACTIVITY. THE PARENT IS AWARE THAT THEY CANNOT HOLD THE SCHOOL DISTRICT RESPONSIBLE FOR ANY ADVERSE OUTCOME OF THIS ACTION.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PLEASE DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911. ALERT EMS TO POSSIBLE ALLERGIC REACTION.