FERNDALE SCHOOL DISTRICT

Physician's Order and Emergency Care Plan
For Allergy/Anaphylaxis

- ***This form must be fully completed to allow for school attendance per RCW 28A.210.320.***

Student ____ Birthdate _____________ School____________________

Identified life-threatening allergen(s) are:

Diagnosis of asthma? ☐ Yes ☐ No

Other ***non-*** life-threatening allergens:

Auto-injector will be stored: ☐ **main office** ☐ **on student** ☐ **other:**

The student named above is authorized to self-administer the epinephrine auto-injector: ☐ Yes ☐ No

Physician's order for epinephrine auto-injector ☐ **0.15 mg** ☐ **0.3 mg**

1. Administer auto-injector if student is unable or not authorized to self-administer **for suspected or actual exposure to above noted life-threatening allergens(s)**
2. Call 911
3. If other medication (ie: antihistamine) is needed, complete separate authorization form.

If epinephrine auto-injector is not immediately available, call 911.

Symptoms of allergic reaction/anaphylaxis may include:

Gastrointestinal:	*Nausea, stomachache, abdominal cramps, vomiting, diarrhea*
Heart:	*Passing out, fainting, pale or bluish skin color*
Lung:	*Shortness of breath, repetitive coughing, wheezing*
Mouth:	*Itching, tingling, or swelling of the lips, tongue or mouth*
Skin:	*Hives, itchy rash, swelling about the face or extremities*
Throat:	*Sense of tightness in the throat, hoarseness, hacking cough*
General:	*Panic, sudden fatigue, chills, fear*
Other:	*Some students may experience symptoms other than those listed above*

Medication Authorization: Health Care Provider and Parent/Legal Guardian signatures required:
I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for a potentially life threatening condition. I understand that **trained unlicensed school personnel** may be delegated to administer the emergency epinephrine auto-injector.

______________________________ ______________________
Health Care Provider (signature) Date

______________________________ ______________________
Health Care Provider (print name) Phone Number

- By signing this, I acknowledge that I have read and understand the information on page 2 of this form.

______________________________ ______________________
Parent/Legal Guardian signature Date

Parent/Legal Guardian- I understand the following:

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- I understand that **trained unlicensed school personnel** may be delegated to administer the emergency epinephrine auto-injector.
- This order must be **renewed each school year.**
- It is recommended that my child wear a medical alert identification (i.e. bracelet or necklace).
- For afterschool activities, athletic events or any school related events outside the regular school-hours parent/legal guardian must make arrangements with the building or program administrator to assure access to epinephrine auto-injector.
- My child qualifies for accommodations and will be placed under Section 504. A copy of rights and information will be provided with the accommodation plan.
- If my child is self-carrying and a back up epinephrine auto-injector is NOT provided to the school, **it is understood that my child is required by law to have it in his/her possession while attending any school sponsored event or activity. The availability of having this emergency medication in my child's possession is solely my child's responsibility and mine.**
- It is my responsibility to make sure that the epinephrine auto-injector(s) is current and unexpired.
- I will update this order if any allergens/conditions have changed.
- The school nurse will instruct the designated staff in the intervention protocol per licensed health care provider's order in the use of the epinephrine auto-injector and signs and symptoms of anaphylaxis.