

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other <u>non</u> - life-threatening allergens:

Auto-injector will be stored: <input type="checkbox"/> main office <input type="checkbox"/> on student <input type="checkbox"/> other: The student named above is authorized to self-administer the epinephrine auto-injector: <input type="checkbox"/> Yes <input type="checkbox"/> No

Physician's order for epinephrine auto-injector <input type="checkbox"/> 0.15 mg <input type="checkbox"/> 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 allergen(s) 2. Call 911 3. If other medication (ie: antihistamine) is needed, complete separate authorization form.
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If epinephrine auto-injector is not immediately available, call 911.	
Symptoms of allergic reaction/anaphylaxis may include:	
Gastrointestinal:	<i>Nausea, stomachache, abdominal cramps, vomiting, diarrhea</i>
Heart:	<i>Passing out, fainting, pale or bluish skin color</i>
Lung:	<i>Shortness of breath, repetitive coughing, wheezing</i>
Mouth:	<i>Itching, tingling, or swelling of the lips, tongue or mouth</i>
Skin:	<i>Hives, itchy rash, swelling about the face or extremities</i>
Throat:	<i>Sense of tightness in the throat, hoarseness, hacking cough</i>
General:	<i>Panic, sudden fatigue, chills, fear</i>
Other:	<i>Some students may experience symptoms other than those listed above</i>

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:

- 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.