Faribault Public Schools
Health Services

ALLERGY HEALTH PLAN AND MEDICATION AUTHORIZATION

Student's Name:____ **D.O.B.**_________________________

This student is allergic to: ____

Previous symptoms of exposure/ingestion of allergen: ____

Epi-Pen prescribed for this student's allergy: ☐ **No** ☐ **Yes - If yes medical provider to complete back of this form.**

SIGNS OF AN ALLERGIC REACTION INCLUDE: (circle symptoms most common to this student)

BODY SYSTEMS	SYMPTOMS
MOUTH	Itching & swelling of the lips, tongue or mouth
THROAT*	Itching and/or a sense of tightness in throat, hoarseness, hacking cough
SKIN	Hives, itchy rash and/or swelling of face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG*	Shortness of breath, repetitive coughing and/or wheezing
HEART*	"thready" pulse, "passing out"

The severity of symptoms can quickly change.
***All above symptoms can potentially progress to a life-threatening situation!**

ACTION:

1. Notify the health office **IMMEDIATELY** to alert staff to bring EPIPEN to the student
2. The EPIPEN must be administered **IMMEDIATELY.**
3. A **CALL** must be placed to **9-911**
   - Request an ambulance
   - Specify that the student is having an Anaphylactic Reaction.
   - Stay with student
   - Monitor breathing, start CPR if no breathing noted
4. Contact Parents

If NO EPIPEN required, complete this section: Steps to be taken for non-Anaphylactic allergic reactions. These might include giving medications (requires medication authorization on back of this form), calling 911, or calling parents, etc.

1. ____
2. ____
3. ____

Please note, if medication is to be given the back of this form must be completed by a prescribing health care professional and parent authorization area to be signed.

Reviewed by: Please Sign the appropriate line below

☞ Parent/Guardian ____ Date _____________

Building RN ____ Date _____________

Health Office Nurse ____ Date _____________

Faribault Public Schools
Health Services

MEDICATION AUTHORIZATION FORM

Name of Student ____ **Date of Birth** ___________________

School _______________________ **Grade** _________ **Homeroom/Advisory/Teacher:** _________________

PRESCRIBER'S ORDER

I have prescribed the following medication to be administered for an allergic reaction during school hours:

Medication	Dosage	Time	Duration

Diagnosis or medical reason for medication:____

☐Yes ☐No **Student is able to self-carry and self-administer epi-pen for treatment of allergic reaction.**

Other medication this student is taking:____

Any other recommendations or UNUSUAL side effects:____

Physicians Signature:____ Today's Date:__________________

Physicians Name (Printed):_______________________________________ Phone Number:_________________

Clinic Name & Address:____ Fax Number: ___________________

PARENT / GUARDIAN AUTHORIZATION – SIGN BELOW

☐ Yes, I hereby authorize my child to self-administer the above medication at school as prescribed by the physician. I authorize reciprocal release of information related to my child's health/medications between the school nurse and the prescribing health professional/clinic. I understand that my child will be responsible to carry this medication at school and its' use will not be monitored by school personnel. I understand that trained school personnel will follow the EPIPEN Emergency Health Plan should my child be unable to self-administer his/her medication. I understand that the school nurse may decide that my child is not able to self-administer medication. If that is the case, the school nurse will contact me and explain the reason.

☐ No, I want my child's above medication kept in the health office and given by trained staff should any symptoms of an allergic reaction happen.

Reviewed by: Please Sign the appropriate line below

☞Parent/Guardian ____ Date _____________

Building RN ____ Date _____________

Health Office Nurse ____ Date _____________

FARIBAULT HEALTH OFFICE FAX NUMBERS

Jefferson Elementary	Fax: 507-333-6544	Faribault Middle School	Fax: 507-333-6400
Lincoln Elementary	Fax 507-333-6642	Faribault High School	Fax: 507-333-6111
Roosevelt Elementary	Fax: 507-333-6734	McKinley Early Childhood Center	Fax: 507-333-6830