MEDICATION ADMINISTRATION FORM FOR ALLERGIC REACTIONS

STUDENT'S NAME: ____________________________________ D.O.B. ______________

ALLERGIC TO: ____Grade:______________
Does student have asthma (Higher risk for severe reaction): Yes _____ No _____

STEP 1 TREATMENT

SYMPTOMS	Health care provider initials appropriate medication	
If food allergen has been ingested or insect sting, but no symptoms:	_____Epinephrine	_____Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	_____Epinephrine	_____Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	_____Epinephrine	_____Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	_____Epinephrine	_____Antihistamine
Throat: Tightening of throat, hoarseness, hacking cough	_____Epinephrine	_____Antihistamine
Lungs: Shortness of breath, repetitive coughing, wheezing	_____Epinephrine	_____Antihistamine
Heart: Weak or thread pulse, low BP, fainting, pale, blueness	_____Epinephrine	_____Antihistamine
If reaction is progressing (several of the above affected areas, give	_____Epinephrine	_____Antihistamine

Medication Orders – All information must be completed

Epinephrine auto-injector administered intramuscularly:
Strength :____
Frequency: ____
If epinephrine auto-injector is administered, 911 will be called for transportation to hospital.

Antihistamine: Name of Medication:____Dosage: ______________
Route: __________________Frequency: ____

Inhaler: Name of Medication:____Dosage: ______________
Route: __________________Frequency: ____

STEP 2: EMERGENCY CALLS

1. If needed, call 911, state an allergic reaction has been treated with an epinephrine auto-injector and additional epinephrine may be needed. 911 will be called if a needed epinephrine auto-injector is not supplied by the parent.
2. Dr. _________________________________ Phone Number __________________
3. Parent ______________________________ Phone Number __________________

This form must be signed after June 30 of new school year by a physician and parent and returned to the school nurse by the first day of school.

Physician's Signature: ____ Date: ______
(no stamped signatures will be accepted)
Printed name of physician: ____

Parent/Guardian Signature: ____

Downingtown Area School District
Parent/Doctor Authorization to Carry Own Medication
Epinephrine Auto-injector

Date: ___________

Student name _________________________ has been instructed and ***provided a return demonstration in the proper use of*** ______________________________. We request that the above named student be permitted to carry his/her medication or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose, appropriate method and frequency of use of his/her medication.

We the undersigned, absolve the school of any responsibility in safeguarding the misuse of our child's medication. The Department of Health, School Health division, requires school nurses to determine if it is safe for a student to carry their own medication.

Please complete the following information: **COMPLETE ALL INFORMATION BELOW!**

Name of medication _____________________ Dose_____________________
If medication is to be taken daily at what time? _________________________
If medication is to be taken when needed, describe indications:
____
How soon can it be repeated? ____
List significant side effects ____
Date to stop medication____
Other information ____

In the event of self-administration of an epinephrine auto-injector, the student will inform a responsible person and 911 will be called. An epinephrine auto-injector use needs to be reported immediately.

_________________________________ _______________________________
Physician Signature (no stamped signatures) Parent Signature

____
Printed Physician's Name

__________________________________ _______________________________
Physician Phone Number Parent Phone Number

Note: Both sides of this form must be completed for those students who request permission to carry their own epinephrine auto-injector with them at all time. It is also suggested that a "back up" medication be kept in the nurse's office.