FERNDALE SCHOOL DISTRICT NO. 502
Ferndale, WA 98248

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: _____ Birth Date: _____
School: _____ Teacher/Counselor: _____

Identified Life-Threatening Allergen(s) are:	
Diagnosis of asthma? ☐Yes ☐No	Medication needed at school? ☐Yes ☐No ☐N/A
Other allergens:	Symptoms:

The Epinephrine auto-injector will be stored: ☐ Main office ☐ On student ☐ Both ☐ Other:

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

1. Administer prescribed 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. Administer the following oral medication: _____Dosage: _____

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. This order must be renewed annually.

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

_____ _____
Health Care Provider (signature) Date

_____ _____
Health Care Provider (print name) Phone Number

_____ _____
Parent/Legal Guardian Signature Date

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Parent/Legal Guardian- I understand the following:

- 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.

_____	_____	_____
Parent/Legal Guardian's Signature	Date	Phone Number