MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

Student	:	Birth Date:		Grade:	
Parent Section Seccion des Padres	I request that the school nurse, or designated staff member, dminister the following medication in accordance with healthcare provider instructions. I understand that this information will be shared with school staff on a "need to know" basis. The school nurse may contact the healthcare provider to discuss/clarify this order as needed. I also understand that expired medication will be properly disposed of by the school nurse unless otherwise requested. Yo pido que la enfermera o personal designado le administre el medicamento recetado de acuerdo con las instrucciones del medico. Yo entiendo que cualquier informacion de este formulario sera communicada al personal escolar que necesite estar informado. La enfermera escolar puede comunicarse el profesional de la si para discutir /aclarar este orden, según sea necesario. También entiendo que los medicamentos expirados estarán adecuadamente desechados por la enfermera de la escuela, a que los solicite. I give permission for my child to carry this emergency medication. Doy permission for my child to self-administer this emergency medication. Yes/si No Doy permission for my child to self-administer this emergency medication. Yes/si No Doy permisso para que mi estudiante pueda administrarse su propio medicamento de emergencia				nal de la sa
	I give permission for the nurse to initiate a 504 Plan. Doy permiso para la enfermera de inciciar un plan 504			Yes/si No os de telefonas Phone #2	
	LICENSED HEALTH (CARE PROVIDER TO COMP			
Describe Student	has severe allergy to: symptoms in previous reactions: also has asthma? NO YES If yes RED: Treatment for Exposure to Al	s, rescue inhaler may	be used after the E	Epinephrine has been given: Y	— ′ES 1
Ex	posure/Suspected Exposure	1. Give Epinephi	ine IM Immediat	ely (side effects: Inc HR, nervousnes	ss)
Se	erious Symptoms: ~Hives, swelling in areas other than allergen contact area. ~Itching, swelling of lips, tongue, throat,or mouth. ~Sense of tightness in throat, hoarseness ~Significant shortness of breath, repetitive coughing, wheezing. ~Nausea, cramps, vomiting, and/or diarrhea. ~Lightheadedness; dizziness; passing out	If symptom Optional: After giving epiner Specify Medical 2. Note time given. 3. Call 911. Ask for 4. Call School Nurs	hrine, giveion:	oport for an allergic reaction.	
OPTION	IAL: Treatment for <i>No Known Exp</i> o	sure to Life-Threa	tening Allergen	WITH Mild Symptoms	_
Mi -	Mrnown Exposure WITH Id Symptoms (please check): Localized hives Localized swelling Other (describe)	OR 1. Give Specify me	mg Antihista edication: uardian antihista	mine has been given and to	
	mmon side effects of antihistamine include wsiness, dry mouth and constipation.		•	otoms develop, s instructed above.	
	ent may carry this emergency medication ent is trained and capable to self-administ		lication. □ Yes □ I	No	
Medicati	on order is valid for duration of currer	nt school year (which	n includes summe	r school).	
Licensed	Health Care Provider Signature		Printed LHC	P Name	_
Date	Health care pi	ovider phone	Health care pr	ovider FAX	-