BCSD Health Services Anaphylaxis Authorization Form 2023-2024

BCSD 5/2023

THIS FORM MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY - PLEASE PRINT

Student's Legal Name:	**Date of Birth:**
List Allergies :	

Prescribed epinephrine type: Auto-Injector	**Prescribed Dose:** ☐ **0.15 mg** Wt <66 lbs green ☐ **0.3 mg** Wt >	**Prescribed Route:** Intramuscular
Prescribed antihistamine:	**Prescribed Dose:**	**Prescribed Route:**

Specific instructions for medication administration (example: give diphenhydramine prior to epinephrine)**:**

Symptoms may start as: (check all that apply)

- ☐ Itching and swelling of the lips, tongue or mouth
- ☐ Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ Hives, itchy rash and/or swelling around the face or extremities
- ☐ Shortness of breath, repetitive coughing and/or wheezing
- ☐ Thready pulse or passing out
- ☐ Other _____

Bus Travel This student must have his/her **epinephrine** available on the bus to and from school: ☐ Yes ☐ No

Student has permission to self-carry / self-administer this medication: ☐ **No** ☐ **Yes – if yes, read the following carefully:**

If yes box is checked, I agree that this student must be allowed to have the above named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

Printed Name of Health Care Provider: _____ Phone: _____

Health Care Provider Signature:_____ **Date**: _____

Parents / Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following*:

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- I give BCSD Health Services my permission to contact the prescribing Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BCSD staff to administer this medication to my child according to district requirements.
- BCSD Transportation department staff are required to complete online training for health emergencies annually. Additional training by a licensed BCSD nurse will be provided as warranted.
- I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s).

My student has orders from our health care provider to Self-Carry/Self-Administer this medication:
☐ ***No*** ☐ ***Yes *If yes, read the following carefully:***

*Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. **My child has been trained by our physician and has demonstrated competency in this procedure.** My child must be allowed to possess this medication at school sponsored activities, in transit to and from school or school-sponsored activities, and during before or after-school activities on school property. I realize that the School District of Beaufort County cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions (except emergency medications). I give the school nurse my permission to contact the physician's office to request medical information concerning my child.

Parent/Legal Guardian Printed Name: _____ Daytime Phone Number: _____

Parent/Legal Guardian Signature: _____ **Date**: _____

This form is only valid if signed on or after July 1st for the upcoming school year.