



CONSENT FORM FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION

****Before medication can be administered by CE program personnel this form must be completed and on file****

Child's Name: _____ Birth Date: _____

Program Name/Site: _____ Grade: _____

PHYSICIAN / LICENSED PRESCRIBER ORDER

Epinephrine auto-injector type: _____ Dose: 0.15 mg IM **or** 0.3 mg IM

Instructions for giving medication: _____

Criteria for repeat dosing: _____

Possible side effects: _____

Other/Additional Directions: _____

Emergency Allergy Medication should be administered for the following type(s) of symptoms:

MOUTH ___

SKIN ___

GUT ___

THROAT ___

LUNGS ___

HEART ___

OTHER ___



Itching & swelling of the lips, tongue, or mouth

Hives over body, widespread redness, itchy

Nausea, abdominal cramps, vomiting, diarrhea

Tight or hoarse throat, trouble breathing or swallowing

Shortness of breath, wheezing, repetitive cough

Pale or bluish skin, fairness, weak pulse, dizziness

Feeling something bad is about to happen, anxiety, confusion

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: _____ DATE: _____

PRINT NAME: _____ PHONE #: _____

CLINIC: _____ FAX #: _____

OVER

Child's Name: _____

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during CE program hours by CE program staff as ordered by the physician/licensed prescriber.
2. I will provide this medication in the original, properly labeled pharmacy container.
3. I authorize the CE Program Coordinator/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
4. I authorize the CE Program Coordinator/designee to communicate with appropriate CE program personnel regarding this medication and emergency care plan for my child.
5. I release CE program personnel from any liability in relation to the administration of this medication during the program.
6. I have read and understand the Medication Guidelines included with this form (below).

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

GUIDELINES FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it.

1. Administration of Emergency Allergy Medication by school personnel will only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian.
 - a. Altered forms of medication will not be accepted or administered during a CE program.
 - b. Medical cannabis will not be administered at CE program.
 - c. Aspirin-containing products will not be administered at CE program.
 - d. Only FDA approved treatments will be provided at CE program.
2. A new medication consent form is required year and when the medication dosage or instructions for administering the medication are changed.
3. If the medication is discontinued, a physician/licensed prescriber is requested.
4. The medication must be brought to and from CE program by a parent/guardian in its original container.
5. The following information must be on the medication container:
 - a. Child's full name
 - b. Name and dosage of medication
 - c. Directions for administration must match the authorization form
 - d. Physician/Licensed Prescriber name
 - e. Date (must be current)
6. Medications are not to be carried by the child and will be kept in a locked box/cabinet designated for medication.