

For _____ School Year (expires at the end of August)

Must be accompanied by "Permission
to Administer Medication at School"
(PTAM) Form

**SHORELINE SCHOOL DISTRICT
TREATMENT ORDER FORM: LIFE THREATENING ALLERGY
LICENSED HEALTH CARE PROVIDER* (LHP) ORDERS**

Note: These orders *must* be renewed every year, before the beginning of each school year.

Ridgecrest Elementary School 16516 10th Avenue NE Shoreline, WA 98155		ATTENTION: NURSES Phone: 206.393.4276 Fax: 206.393.4193			
Student Name: _____ Birth date _____ Grade/Grad Yr _____ LHP* Name _____ Phone _____ Fax _____					
MEDICAL INFORMATION AND ORDERS – TO BE COMPLETED BY LHP* <i>**Please complete these treatment orders so we can better understand the student's needs**</i>					
<u>STUDENT HEALTH HISTORY:</u> Student has a severe allergy to: _____ Student has a history of anaphylaxis ☐ Yes ☐ No Last anaphylactic reaction (Date) _____ Student has a history of asthma ☐ Yes (High Risk for Severe Reaction) ☐ No Weight: _____ Other related health history: _____					
<u>TREATMENT PLAN: IF ANAPHYLAXIS IS SUSPECTED:*</u> 1. Give epinephrine auto-injector and call 911 2. If available repeat dose of epinephrine in _____ minutes if no improvement 3. Give antihistamine and inhaler (bronchodilator) if available (<i>see attached PTAM form for medical orders</i>) 4. Other: _____ Student may carry emergency medication in backpack: ☐ YES ☐ NO Student may self-administer epinephrine auto-injector: ☐ YES ☐ NO Student has demonstrated use of epinephrine auto-injector to LHP* ☐ YES ☐ NO					
<u>Additional instructions for certain students:</u> The student is EXTREMELY reactive to the following allergen(s): _____ ☐ If checked, give epinephrine immediately if student LIKELY exposed to allergen, for ANY symptoms. ☐ If checked, give epinephrine immediately if student DEFINITELY exposed to allergen, even if no symptoms are apparent.					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; padding: 5px;"> Licensed Health Care Provider* Signature </td> <td style="width: 20%; text-align: center; padding: 5px;"> Date </td> <td style="width: 30%; text-align: center; padding: 5px;"> Phone </td> </tr> </table>			Licensed Health Care Provider* Signature	Date	Phone
Licensed Health Care Provider* Signature	Date	Phone			
*Any of the following symptoms: LUNG: Shortness of breath, wheezing, repetitive cough HEART: Pale or bluish skin, faintness, weak pulse, dizziness THROAT: Tight or hoarse throat, trouble breathing or swallowing MOUTH: Significant swelling of the tongue or lips SKIN: Many hives over body, widespread redness GUT: Repetitive vomiting, severe diarrhea OTHER: Feeling something bad is going to happen, anxiety, confusion STUDENT SPECIFIC: _____					
<div style="text-align: right;"> *OR A COMBINATION OF MILD SYMPTOMS FROM DIFFERENT BODY AREAS. </div>					

*MD, DO, ARNP, PA, ND