

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

**SHORELINE SCHOOL DISTRICT
TREATMENT ORDER FORM: LIFE
THREATENING ALLERGY**

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

LICENSED HEALTH CARE PROVIDER* (LHP) ORDERS

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

Shorecrest High 153423 25th Ave NE Phone: 206-393-4308 Shoreline, WA 98155	ATTENTION: School Nurse Fax: 206-393-4284	
Student Name: _____ Birth date _____ Grade/Grad Yr _____ LHP* Name _____ Phone _____ Fax _____		
MEDICAL INFORMATION AND ORDERS – TO BE COMPLETED BY LHP* **Please complete these treatment orders so we can better understand the student's needs**		
<u>STUDENT HEALTH HISTORY:</u> Student has a severe allergy to: _____ Student has a history of anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No Last anaphylactic reaction (Date) _____ Student has a history of asthma <input type="checkbox"/> Yes (High Risk for Severe Reaction) <input type="checkbox"/> No Weight: _____ Other related health history: _____		
<u>TREATMENT PLAN: IF ANAPHYLAXIS IS SUSPECTED:*</u> 1. Give epinephrine auto-injector and call 911 2. Repeat dose of epinephrine (if available) in _____ minutes if no improvement 3. Give antihistamine and inhaler (bronchodilator) if available (<i>see attached PTAM form for med orders</i>) 4. Other: _____ _____ Student may carry emergency medication in backpack: <input type="checkbox"/> YES <input type="checkbox"/> NO Student may self-administer epinephrine auto-injector: <input type="checkbox"/> YES <input type="checkbox"/> NO Student has demonstrated use of epinephrine auto-injector to LHP* <input type="checkbox"/> YES <input type="checkbox"/> NO		
<u>Additional instructions for certain students:</u> The student is EXTREMELY reactive to the following allergen(s): _____ <input type="checkbox"/> If checked, give epinephrine immediately if student LIKELY exposed to allergen, for ANY symptoms. <input type="checkbox"/> If checked, give epinephrine immediately if student DEFINITELY exposed to allergen, even if no symptoms are apparent.		
_____ Licensed Health Care Provider* Signature	_____ Date	_____ Phone

*MD, DO, ARNP, PA, ND

***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: _____

***OR A COMBINATION OF MILD
SYMPTOMS FROM DIFFERENT
BODY AREAS.**