








FEDERAL WAY PUBLIC SCHOOLS
SEVERE ALLERGIC REACTION TREATMENT ORDERS

STUDENT NAME		DOB		ID NUMBER	
SCHOOL		GRADE		ACADEMIC YR	

TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER

Student is allergic to: _____

Student has asthma No Yes (at increased risk for developing anaphylaxis)

Symptoms of Anaphylaxis							
							OR A COMBINATION of symptoms from different body areas.
LUNG	HEART	THROAT	MOUTH	SKIN	GUT	OTHER	
Short of breath, wheezing, repetitive cough	Pale, blue, faint, weak pulse, dizzy	Tight, hoarse, trouble breathing/ swallowing	Significant swelling of the tongue and/or lips	Many hives over body, widespread redness	Repetitive vomiting, severe diarrhea	Feeling something bad is about to happen, anxiety, confusion	

Treatment Plan for preventing/treating anaphylaxis at schools is as follows: (check all that apply)

1. **Give epinephrine IMMEDIATELY** if student is exposed to allergen and/or exhibits any symptom of anaphylaxis.
 - Epinephrine auto-injector 0.3 mg
 - Epinephrine auto-injector 0.15 mg
 - Repeat dose of epinephrine may be given (if available) in 10-15 minutes if symptoms not relieved and EMS has not arrived.
2. **Call 911 at the time epinephrine is given and notify parent/guardian.**
3. After epinephrine is given, administer the following medication (antihistamine, albuterol, etc.) if available
 - _____ (Name of medication) _____ (Dose & route) _____ (Other instructions)
 - _____ (Name of medication) _____ (Dose & route) _____ (Other instructions)

Student and parent/guardian have been instructed in use of epinephrine auto-injector. Yes No

Student may carry and self-administer Epinephrine auto-injector, antihistamine, and/or albuterol inhaler. Yes No

Student may also use rescue inhaler for signs and symptoms of asthma unrelated to anaphylaxis. Yes No

Duration: Entire school year Specific date (not to exceed current school year): _____

Provider Signature		Provider Name		Date	
Clinic Name		Phone		Fax	

TO BE COMPLETED BY A PARENT/GUARDIAN

I request that medication be given to my student as ordered by the licensed health professional (LHP). I give Health Services staff permission to communicate with the LHP/medical staff about this medication and the condition for which it is prescribed. I understand that medication may be given by a school nurse or trained school staff. I release school staff from any liability in the administration of this medication at school. I agree to notify the school nurse if my student decides to participate in any district-sponsored activity outside of the normal school day (sports, clubs, etc.). I request and authorize my student to carry and/or self-administer this medication (Yes No) with the understanding that permission to self-administer may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer.

Parent/Guardian Signature	Date
School Nurse Signature	Date