Lakewood School District #306
P.O. Box 220 N. Lakewood, WA 98259
School Building Fax #: _____

AUTHORIZATION FOR ADMINISTRATION OF EPI-PEN/ANTIHISTAMINE AT SCHOOL

Student Name: _____ Birth Date: _____ Sex: M / F
School: _____ Teacher: _____ Grade: _____

ANAPYLAXIS ALLERGY TO: _____
OTHER ALLERGIES TO: _____
Has the student had a previous anaphylactic reaction requiring the use of an Epi-Pen? □ Yes* □ No
(* If yes, in the event of an allergen exposure or potential exposure, school staff will immediately administer the epi pen and call 911)
Does the student also have asthma? □ Yes * □ No (*Yes, means there is a higher risk for severe reaction)
Is there an Inhaler Prescribed? □ Yes □ No

HEALTH CARE PROVIDER completes this section: (*please print*)

Antihistamine: _____ **Dose**: _____

□ Tablet/Capsule □ Liquid □ Other _____

How soon can it be repeated? _____

Diagnosis/ Reason for Medication: _____

Significant Side Effects: _____

Epi-Pen: □ 0.15mg (JR) □ 0.30mg

Repeat Dose? □ Yes □ No **When to Repeat?** _____

Child may carry and self-administer Epi-Pen □ Yes □ No

Diagnosis/ Reason for Medication: _____

Significant Side Effects: _____

Indications for Administration of Epi-Pen/Antihistamine:

Mild Symptoms:	**Give Checked Medications** (please check only one):
Mouth: Itching, tingling, or mild swelling of the lips	□ Epi pen □ Antihistamine
Skin: Mild itchy, few hives, and/or rash	□ Epi pen □ Antihistamine
Nose: Itchy or runny nose, sneezing	□ Epi pen □ Antihistamine
GI: Mild nausea and/or abdominal cramps	□ Epi pen □ Antihistamine
Severe Symptoms:	**Give Checked Medications** (please check only one):
Lungs: Shortness of breath, repetitive coughing, or wheezing	□ Epi pen □ Antihistamine
Throat: Tightening of throat, hoarseness, or hacking cough	□ Epi pen □ Antihistamine
Heart: Weak pulse, low blood pressure, fainting, pale or blue	□ Epi pen □ Antihistamine
Mouth: Significant swelling of tongue or lips	□ Epi pen □ Antihistamine
Skin: Severe hives or redness	□ Epi pen □ Antihistamine
GI: Significant nausea, repetitive vomiting or severe diarrhea	□ Epi pen □ Antihistamine
Other: Anxiety, confusion, or feeling like something bad will happen	□ Epi pen □ Antihistamine

Health Care Provider Signature: _____ Date: _____

Print Name: _____ Phone #: _____ Fax #: _____

PARENT/GUARDIAN completes this section:

If your child has a reaction and his/her Epi-Pen is unavailable, does the school have permission to use a stock Epi-Pen?

□ Yes □ No

I request that my child be allowed to take the medication as described above. I will provide the medication in the original, properly labeled container. I understand that if I do not pick up any medication left at the end of the school year, it will be destroyed. I give my permission for school staff to communicate freely with this health care provider. I understand that my signature indicates my understanding that the school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and in accordance with the District Policy and Procedure 3416 and 3416P.

Parent/Guardian Signature: _____ Date: _____ Daytime Phone: _____ Emergency Phone: _____

Reviewed by School Nurse: _____ **Date**: _____

Reviewed by District Nurse: _____ **Date**: _____

3/16 KM