MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

Grand Coulee Dam School District

Student:_____ **Birth Date:**_____ **Grade:**_____

ALLERGIC TO:_____

TO BE COMPLETED BY PARENT OR GUARDIAN

I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions.

☐ Yes ☐ No I request my child be assessed for eligibility to carry this medication.
☐ Yes ☐ No I give permission for my child to carry and self-administer this medication upon approval of the School Nurse.
☐ Yes ☐ No I understand the permission to carry and/or self-administer medication may be revoked by principal/School Nurse for safety reasons.
☐ Yes ☐ No I give Health Services permission to communicate with the LHP/medical office staff about this plan/medication.

I understand that medication at school may need to be given by an unlicensed staff member who has received training from the School Nurse.

I understand this is a plan for a life-threatening condition and can only be discontinued, in writing, by the LHP. I understand medical information may be shared with school staff who work with my child and with 911 staff, if they are called.

_____	_____	_____	_____
Signature	*Date*	*Phone #1*	*Phone #2*

—----------LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW—----------

Student's allergy has been determined by: ☐ Testing ☐ Parent Report ☐ Other _____

Describe symptoms in previous reactions: _____

Student may need Epinephrine on the **bus**? ☐ Yes ☐ No (If yes, please prescribe 2 autoinjectors)

Student also has asthma? ☐ No ☐ Yes (Asthma Management Form Needed)

If yes, rescue inhaler may be used **after** the Epinephrine has been given: ☐ Yes ☐ No

REQUIRED TREATMENT FOR SERIOUS SYMPTOMS OR KNOWN / SUSPECTED EXPOSURE

Exposure/Suspected Exposure
OR
Serious Symptoms:

- Mouth - Itching, tingling, or swelling of lips, tongue, or mouth
- Throat - Sense of tightness in throat, hoarseness, and hacking cough.
- Lung - Shortness of breath, repetitive coughing and/or wheezing, sense of tightness in chest.
- Skin - Hives, itchy rash, and/or swelling of face or extremities, pale or blue-ish skin
- Gut - Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea
- General - Panic, sudden fatigue, chills, fear, sense of impending doom, fainting

1. **Give Epinephrine Immediately if student is experiencing serious symptoms from 2 or more organ systems.** *side effects: HR, nervousness, shakine*
   Epinephrine auto-injector: ☐ 0.15mg OR ☐ 0.3mg
   Medication located in: ☐Health Room ☐Self-Carry

   ☐ If symptoms continue, repeat Epinephrine after 5 - 10 minutes.
   (If repeat dose ordered, please provide school with 2nd dose.)

Antihistamine will not be administered as treatment for Anaphylaxis by an unlicensed staff member.

2. Note time given
3. **Call 911**, ask for Advanced Life Support for an allergic reaction
4. Call School Nurse (if available) and notify parent/guardian
5. Remain with student until EMS arrives. Student should be lying down
6. Student may not remain at school if Epinephrine is administered

Recommend student carry this emergency medication at school. ☐ Yes ☐ No
This student is trained and recommended to self-administer this emergency medication. ☐ Yes ☐ No

Medication order is valid for the _____ school year (which includes summer school).

_____ _____
Licensed Health Care Provider Signature *Printed LHCP Name*

_____ _____
Date *Health care provider phone*

School Nurse Approved to Self Carry? ☐ Yes ☐ No *School Nurse Signature* _____

This form is for emergency treatment orders only. If a student requires an antihistamine for mild allergy symptoms like runny nose or watery eyes, a non-emergent oral medication authorization form will need to be completed.