



Student Name:		DOB:	School:
Parent/Guardian 1:		Phone:	
Parent/Guardian 2:		Phone:	
Provider:	Phone:	Fax:	
Clinic:		Preferred Hospital:	

Student has asthma: yes (more at risk for severe reaction) no

**Extremely reaction to the following allergens:** \_\_\_\_\_  
THEREFORE:

- If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.  
 If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are present.

FOR ANY OF THE FOLLOWING:  
**SEVERE SYMPTOMS**

 <b>LUNG</b> Shortness of breath, wheezing, repetitive cough	 <b>HEART</b> Pale or bluish skin, faintness, weak pulse, dizziness	 <b>THROAT</b> Tight or hoarse throat, trouble breathing or swallowing	 <b>MOUTH</b> Significant swelling of the tongue or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	<b>OR A COMBINATION</b> of symptoms from different body areas.

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- ADMINISTER EPINEPHRINE IMMEDIATELY.**
- Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

 <b>NOSE</b> Itchy or runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea or discomfort
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**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM (intramuscular)  0.15 mg IM  
 0.3 mg IM  1 mg IN (intranasal)  2 mg IN

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

Patient may self-carry  Patient may self-administer

**Preventative measures:**

- Avoid known allergens
- Peanut/nut aware classroom required: yes no
- Able to eat snacks provided by school outside of the cafeteria: yes no
- Needs to sit at a peanut/nut aware lunch table (if a student requires a peanut/nut aware classroom, this will automatically be required to sit at this lunch table): yes no

1. I request that the above medication/treatment be administered to my student as prescribed by the healthcare provider. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
2. I understand I must provide medication in the original bottle, properly labeled by the pharmacy with the student's name, date, dosage, time and directions for administration.
3. I give permission for the medication(s) to be given by school personnel as delegated by the licensed school nurse.
4. I understand and authorize my child's healthcare provider to release or share my child's protected health information regarding this medication and/or medical condition.
5. If my student has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my student. I will notify the Health Office if I prefer to pick it up. All controlled substances will need to be picked up. If medication is left over and not picked up within 2 weeks after expiration or conclusion of the school year, it will be disposed of.
6. I will immediately notify Health Services of any change in the medication(s) i.e dose change, medication, discontinued, etc.
7. I understand it is my responsibility to notify the transportation company directly of any specific directions for my student's care while riding transportation before or after school.

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_