

G1: Severe (Life-Threatening) Allergy Medication Order

(G3: Student Food Allergy Assessment Form is also required from parent/guardian).



Student Name _____

Birth date _____

This section to be completed by a Licensed Healthcare Provider (LHP)

→ Student has severe allergy to: _____

When a school nurse is NOT AVAILABLE, trained staff will administer epinephrine without delay if there are any allergy symptoms or known ingestion as indicated in Student's Emergency Action Plan (EAP). If a student has symptoms or you suspect exposure (is stung, eats food he/she is allergic to, or exposed to something allergic to):

Give EpiPen Auto-Injector:

☐ 0.3 mg

☐ Jr. 0.15 mg

☐ May repeat epinephrine (if available) in _____ minutes if symptoms are not relieved or symptoms return, and EMS has not arrived.

Give neffy (epinephrine nasal spray)

☐ One spray of neffy 1 mg

☐ One spray of neffy 2 mg

Document time medications were given below and alert EMS when they arrive.

Epinephrine #1: _____

Epinephrine #2: _____

Antihistamine: _____

Inhaler: _____

1. Stay with student.

2. CALL 911 – Advise EMS that student has been given epinephrine.

3. Notify parents and school nurse.

4. After epinephrine has been used, give Benadryl®: ☐ Yes _____ (ml/mg/cc) OR antihistamine ☐ Yes _____ (ml/mg/cc)

5. If student has history of asthma and is having wheezing, shortness of breath, chest tightness with allergic reaction:

After epinephrine and antihistamine, may give:

☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®)

☐ Other: _____

☐ Levalbuterol 2 puffs (Xopenex®)

☐ Albuterol/ Levalbuterol unit dose SVN (per nebulizer)

6. A student given a epinephrine must be monitored by medical personnel or a parent and may NOT remain at school.

SIDE EFFECTS of medication(s):

Epinephrine: _____

Antihistamine: _____

Albuterol/Levalbuterol: _____

☐ Student may carry & self-administer epinephrine +/- or antihistamine

☐ Student may carry & self-administer inhaler

☐ Student has demonstrated epinephrine use in LHP's office

☐ Student has demonstrated inhaler use LHP's office

Information required for District Food & Nutrition Services, per USDA Guidelines. If instructions are not clear, we will seek written clarification.

Specific "Food/Ingredient/Additive" to OMIT/RESTRICT during meal service: _____

Foods to be SUBSTITUTED (if applicable): _____

☐ May have baked goods with small amount of eggs

LHP Signature: _____ Print Name: _____

Start date: _____ End date (not to exceed current school year): _____ ☐ Last day of school ☐ Other: _____

Date: _____ Phone #: _____ Fax #: _____

• I request this medication to be given as ordered by the licensed health professional (LHP) (i.e.: doctor, nurse practitioner, PAC).

• I give health services staff permission to communicate with the LHP/medical office staff about his medication.

• I understand that any medication will not necessarily be given by a school nurse but may be given by trained and supervised school staff.

• Medical/medication information may be shared with school staff working with my child and 911 staff, if they are called.

• All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.

• Student is encouraged to wear a medical ID bracelet identifying the medical condition.

→ I request and authorize my child to carry and/or self-administer their medication. ☐ Yes ☐ No

→ This permission to possess and self-administer any medication 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: _____

For Use by District Nurse Only

Student has demonstrated to the nurse the skill necessary to use the medication and any device necessary to self-administer the medication.

Device(s) if any, used _____

Expiration date(s) _____

School nurse signature _____

Date _____