PASCO SCHOOL DISTRICT #1

Medical Authorization for Severe Allergy Management
McClintock STEM Elementary Fax: 509-416-7827

Name:_____	**ID#** _____	**DOB:** _____	**School Year:** 2025- 2026

PARENT/GUARDIAN SECTION * *SECCION DE PADRE/GUARDIAN*

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize administration of the medication identified below in accordance with the prescription and Health Care Provider's instructions (not to exceed one school year). **Medication will be in the original container.** This information may be shared with school personnel as needed for the wellbeing of my child.

Yo certifico que yo soy el padre/madre, tutor, u otra persona con control legal del susodicho estudiante y pido y autorizo la administración de la antedicha medicina de acuerdo con la receta o las instrucciones del médico (no exceder un año escolar). ***La medicina estará en su envase original.*** *Esta información peude que sea compartida con personal de la escuela según la necesidad del bienestar de mi hijo/hija.*

_____	_____	_____
Parent/Guardian Signature *Firma de Padre/Guardian*	Date *Fecha*	Home phone / Emergency phone *Teléfono de Casa* / *Teléfono de Emergencia*

SECONDARY ONLY:
If this medication is self-carry/administration; will an extra be provided for office? ☐YES ☐NO

THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER (LHCP):

ALLERGY TO: _____

LIFE-THREATENING ALLERGY: ☐ YES *(EpiPen or Neffy Required)* ☐ NO

ALLERGY HISTORY: ☐ History of anaphylaxis/severe reaction Date of Last reaction: (if applicable) _____

Brief Description of previous reaction(s): _____

Confirmed by allergy testing? ☐ YES ☐ NO *If YES, Date of Testing*: _____

Receiving any allergy treatment or therapy? Specify: _____

Please check if applicable: ☐ Student has Asthma– increased risk for severe reaction

Is this student prescribed a rescue inhaler? ☐ YES ☐ NO

MEDICATION ORDERS:

For **SEVERE SYMPTOMS** after suspected or known ingestion/sting:

Administer EPINEPHRINE AUTO-INJECTOR: ☐ Epinephrine 0.3mg ☐ Epinephrine 0.15mg (Jr.)

☐ May repeat EAI (if available) in 10-15 minutes if symptoms are not relieved and EMS has not arrived

Administer NEFFY EPINEPHRINE NASAL SPRAY: ☐ Neffy 2mg

☐ May repeat Neffy (if available) in 5 minutes if symptoms are not relieved and EMS has not arrived

For **ONE MILD Symptom ONLY** (itchy mouth, a few hives to face, mild itch, or slight nausea) **OR AFTER EpiPen/Neffy**

Administer ANTIHISTAMINE: _____ Dose: _____

*ONLY Licensed medical professional(s) to provide antihistamine prior to EpiPen or Neffy for singular symptoms****

OTHER (if Asthmatic): Rescue Inhaler for wheezing, shortness of breath, chest tightness with allergic reaction only **AFTER** rescue med and antihistamine administration.

Give: ☐ Albuterol _____ puff(s) ☐ Levalbuterol _____ puff(s)

Medication order is valid for duration of current school year (which includes summer school).

This student may carry this emergency medication at school.	☐ Yes	☐ No
This student is trained and capable of self-administering this emergency medication.	☐ Yes	☐ No
School Nurse approves self-carry and self-administration for this student.	☐ Yes	☐ No

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

_____	_____	_____
Date	*Health care provider phone*	*Health care provider FAX*