

For _____ School Year
(expires at the end of
August)

**SHORELINE SCHOOL DISTRICT
TREATMENT ORDER FORM:
LIFE THREATENING ALLERGY**

Must be accompanied by
"Permission to Administer
Medication at School"
(PTAM) Form

LICENSED HEALTH CARE PROVIDER* (LHP) ORDERS

Note: These orders *must* be renewed **EVERY YEAR**, **before** the beginning of each school year.

Briarcrest Elementary School 2715 NE 158th St Shoreline, WA 98155	ATTENTION: Susan Vieira, RN Phone 206-393-4176 Fax 206-393-4174 EMAIL susan.vieira@ssd412.org
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Student Name: _____ Birth date _____ Grade/Grad Year _____

LHP* Name _____ Phone _____ Fax _____

MEDICAL INFORMATION AND ORDERS – TO BE COMPLETED and SIGNED BY LHP*
*****Please complete these treatment orders so we can better understand the student's needs*****

STUDENT HEALTH HISTORY:

Student has a severe allergy to: _____

Student has a history of anaphylaxis ☐ **Yes** ☐ **No** Last anaphylactic reaction (Date) _____

Student has a history of asthma ☐ **Yes** (High Risk for Severe Reaction) ☐ **No**

Weight: _____

Other related health history: _____

TREATMENT PLAN: IF ANAPHYLAXIS IS SUSPECTED:**

1. Give epinephrine auto-injector and call 911
2. Repeat dose of epinephrine if available in _____ minutes if no improvement
3. Give antihistamine and inhaler (bronchodilator) if available (*see attached PTAM form for med orders*)
4. Other: _____

Student may carry emergency medication in backpack: ☐ YES ☐ NO

Student may self-administer epinephrine auto-injector: ☐ YES ☐ NO

Student has demonstrated use of epinephrine auto-injector to LHP* ☐ YES ☐ NO

*****ANY of the following symptoms:***

LUNG: Shortness of breath, wheezing, repetitive cough

HEART: Pale or bluish skin, faintness, weak pulse, dizzy

THROAT: Tight or hoarse throat, trouble breathing or swallowing

MOUTH: Significant swelling of the tongue or lips

GUT: Repetitive vomiting, severe diarrhea

STUDENT SPECIFIC: _____

OR A COMBINATION OF MILD SYMPTOMS FROM DIFFERENT BODY AREAS

CONTINUED ON NEXT PAGE

Additional instructions for certain students:

The student is **EXTREMELY** reactive to the following allergen(s):

- ☐ If checked, give epinephrine immediately if student **LIKELY** exposed to allergen, for ANY symptoms.
- ☐ If checked, give epinephrine immediately if student **DEFINITELY** exposed to allergen, even if no symptoms are apparent.

Licensed Health Care Provider* Signature

Date

Phone

+Any of the following symptoms:

LUNG: Shortness of breath, wheezing,
repetitive cough

HEART: Pale or bluish skin, faintness, weak
pulse, dizziness

THROAT: Tight or hoarse throat, trouble
breathing or swallowing

MOUTH: Significant swelling of the tongue or
lips

SKIN: Many hives over body, widespread
redness

GUT: Repetitive vomiting, severe diarrhea

OTHER: Feeling something bad is going to
happen, anxiety, confusion

STUDENT

SPECIFIC: _____

***OR A COMBINATION OF MILD SYMPTOMS FROM DIFFERENT BODY
AREAS.**