

MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

AUTORIZACIÓN MÉDICA PARA MANEJO DE ALERGIA SEVERA EN LA ESCUELA

Student/Estudiante: _____ Birthdate/Fecha de Nacimiento: _____ Grade/Grado: _____
 Nurse/Enfermera(o): _____ Phone/Teléfono: _____ School/Escuela: _____ FAX: (509) 573-5050

Parent Section Sección de los padres	I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions. By signing below, I authorize that medical information pertaining to Severe Allergies and use of the following medications be exchanged with my student's school nurse in written and verbal forms. I further give permission for these orders to be faxed to the school. <i>Yo pido que la enfermera o personal designado administre el siguiente medicamento recetado de acuerdo con las instrucciones del médico. Al firmar abajo doy autorización para que la información médica pertinente a Alergias Severas y al uso de los siguientes medicamentos sea comunicada con la enfermera de la escuela de mi estudiante en forma verbal y escrita. También doy permiso para que estas órdenes se envíen por fax a la escuela.</i>			
	I give permission for my child to self-administer and carry this medication. ☐ Yes/Si ☐ No <i>Doy permiso para que mi hijo se administre y cargue este medicamento.</i>			
	I give permission for the nurse to initiate an Emergency Care Plan/504 Plan. ☐ Yes/Si ☐ No <i>Doy permiso para que la enfermera inicie un plan de cuidado de emergencia/plan 504.</i>			
	Signature/Firma _____ Date/Fecha _____ Phone #1 _____		Números de teléfonos _____ Phone #2 _____	

Student has severe allergy to/El estudiante tiene alergia severa a: _____

Describe symptoms in previous reactions/Describe los síntomas en reacciones previas: _____

- - - - - **LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW** - - - - -
 - - - **EL PROVEEDOR DE SERVICIOS DE SALUD AUTORIZADO DEBE COMPLETAR LA SECCIÓN DE ABAJO** - - -

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

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

REQUIRED Treatment for Exposure to Allergen/Suspected Exposure OR Serious Symptoms

Exposure/Suspected Exposure OR Serious Symptoms: - Hives or swelling in areas other than allergen contact area - Itching, swelling of lips, tongue, throat, or mouth - Sense of tightness in throat, hoarseness - Significant shortness of breath, repetitive coughing, wheezing - Nausea, cramps, vomiting, and/or diarrhea - Lightheadedness; dizziness; passing out	1. Give Epinephrine Immediately (side effects: ↑HR, nervousness) Epinephrine IM auto-injector: ☐ 0.15 mg OR ☐ 0.3 mg OR Epinephrine nasal spray (Neffy): ☐ 1 mg OR ☐ 2 mg <i>(If repeat dose ordered, please provide school with 2nd dose.)</i> Optional: ☐ After giving epinephrine, give _____mg antihistamine <i>specify medication:</i> _____ 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
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OPTIONAL With Nurse On Site: Treatment for No Known Exposure WITH Mild Symptoms

No Known Exposure WITH Mild Symptoms (please check): ☐ A few hives ☐ Other (describe) _____ <i>Common side effects of antihistamine include drowsiness, dry mouth and constipation.</i>	☐ Notify parent/guardian to pick up student for observation OR ☐ 1. Give _____mg antihistamine <i>specify medication:</i> _____ 2. Notify parent/guardian that antihistamine was given and to pick student up for further observation. ☐ If serious symptoms develop, give Epinephrine as instructed above.
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Recommend student self-administer and carry this emergency medication at school. ☐ Yes ☐ No

Recommend Medication on bus. **If yes, Student will need two Epi's for school** ☐ Yes ☐ No

Medication order is valid for duration of school year _____ (includes summer school)

 Licensed Health Care Provider Signature

 Printed LHCP Name

 Date

 Health care provider phone

 Health care provider FAX

 Approval to self-carry: Nurse

 Principal