

**ANAPHYLAXIS MEDICATION ADMINISTRATION AUTHORIZATION**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

**This section to be completed by HEALTH CARE PROVIDER**

<b>ANAPHYLACTIC ALLERGEN(S):</b>	
<b>Medication: EPINEPHRINE</b>	<b>Medication: ANTIHISTAMINE</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Intramuscular: <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.3mg <input type="checkbox"/> _____	<input type="checkbox"/> Benadryl/Diphenhydramine: _____ mg
Intranasal: <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg	<input type="checkbox"/> Zyrtec/Cetirizine: _____ mg
	<input type="checkbox"/> _____ : _____ mg
<b>Possible side effects:</b> fast/irregular heartbeat, sweating, shaking, paleness, headache, anxiety, restlessness and/or nausea/vomiting <input type="checkbox"/> Other: _____	<b>Possible side effects:</b> Drowsiness, dry mouth, dizziness, constipation, blurry vision <input type="checkbox"/> Other: _____
<b>Time between doses:</b>	<b>Time between doses:</b>
<b>Indications for administration:</b> <input checked="" type="checkbox"/> Exposure or suspected exposure to allergen <input checked="" type="checkbox"/> Signs of anaphylaxis <input type="checkbox"/> Other: _____	<b>Indications for administration:</b> <input checked="" type="checkbox"/> Exposure or suspected exposure to allergen <input checked="" type="checkbox"/> Signs of anaphylaxis <input type="checkbox"/> Other: _____
<b>Self-carry/Self-administration Authorization</b>	
Do you authorize this student to self-carry these medications <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
This student is trained and capable of self-administering these medications <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
<b>Duration of Order:</b> <input type="checkbox"/> _____ school year, including summer school <input type="checkbox"/> Other Dates: _____	

I request and authorize that the above-named student be administered the above identified medications in accordance with the instructions indicated. There exists a valid health reason which makes administration of these medications advisable during school hours or during such time that the student is under the supervision of school officials. Medication may be administered by non-licensed school personnel.

\_\_\_\_\_  
Health Care Provider Signature                      Printed Name                      Date                      Phone Number                      Fax Number

**This section to be completed by PARENT/GUARDIAN**

- I authorize the school to administer the above-named medication to my student as prescribed.
- I understand that over-the-counter medication must be in its original container with a valid expiration date, and prescription medication must have a pharmacy label matching the written order above. It is my responsibility to replace medication when it is used or expired.
- If my student has permission to self-carry and/or self-administer this medication, my student and I understand the responsibilities, and recognize the school will not track compliance, expiration dates, or remaining amounts.
- I agree to hold harmless and indemnify the Lake Washington School District and its officers, employees, and agents against all claims, demands, damages, costs, judgments, or liabilities arising out of the self-administration and/or carrying of medication by my student.

I understand and acknowledge that:

- A district RN may not always be available to administer the above-named medication to my student or to assess the progression of symptoms. **District procedure is to administer epinephrine immediately and call 911 if a student has an exposure or a suspected exposure to an allergen or signs of anaphylaxis.** Epinephrine will be given first. If an antihistamine is prescribed and available, it will be administered following epinephrine.

\_\_\_\_\_  
Signature of Parent/Guardian                      Printed Name                      Date