Severe Allergy Management for the School Setting

Last Name:_____ First Name: _____
School Year:_____ Effective Dates:_____
Date of Birth (mm/dd/yyyy):_____ Medical Record #:_____
School Name:_____ School Contact Phone #:_____
Parent/Guardian Name:_____ Parent/Guardian Phone #: _____
Emergency Contact:_____ Emergency Phone #:_____
Health Care Provider Name:_____ Health Care Provider Phone #:_____

The following information is to be provided by the student's physician:
Severely Allergic To: _____
History of Allergic Reactions
What was the allergen:_____ Total reactions: _____
Treatment provided: _____ Date of last reaction: _____

Other medical information (check if applicable): ❑ Asthma ❑ Inhaler at school ❑ Medical ID worn

Signs of an Allergic Reaction-*Note: Severity of symptoms can change quickly.*

Systems:	Symptoms:
***Throat**	**Irritation and/or a sense of tightness in the throat, hoarseness, hacking cough**
***Lungs**	**Shortness of breath, repetitive coughing, wheezing, overall difficulty breathing**
***Heart**	**Fainting, pale, blueness, thready pulse**
Mouth	Itching, tingling and swelling of the lips, tongue, or mouth
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, diarrhea

Other: _____

Action for Minor Reaction

1. If the only symptom(s) is/are: _____
   Give: _____ Medication/Dose/Route: _____
2. Call: Parent/Guardian or emergency contacts (see phone numbers below).

If the condition does not improve within 10 minutes, follow the steps for a major reaction below.

Action for Major Reaction

1. If anaphylaxis is suspected and/or symptoms are: _____
   Give: _____ Medication/Dose/Route: _____
2. **Call 911**. Do not hesitate. **Ask for advanced life support**. State that an allergic reaction has been treated and additional epinephrine may be needed.
3. Call Parent/Guardian or emergency contacts (see phone numbers below).
4. Call District Nurse.

Is this student competent to carry/self administer their own medication: ❑ **Yes** ❑ **No**

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.

_____/_____ _____
Name Signature Date

Physician's Stamp (Required)

Parent/Guardian (Authorization and Disclaimer): I request that the school assist my child with the above medications in accordance with state laws and regulations. Should the doctor determine that my child is competent to carry and self administer above medications I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self administration of above medications.

_____/_____ _____
Name Signature Date

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