PALO ALTO
UNIFIED SCHOOL DISTRICT

Medication Authorization
Allergic Reaction/Anaphylaxis Consent Form
School Hours, Field Trips, and Disasters

School Year: _____ School: _____

Student Name: _____ Grade: _____ DOB: _____

List All Allergies:: _____ Asthma: ☐ Yes ☐ No Wt.: _____

*This form **must be renewed each school year**, **and** when there are any changes in treatment or medication during the school year.*

Physician Authorization (To Be Completed by a California Licensed Health Care Provider)

For **SEVERE** allergic reaction symptoms, including shortness of breath, wheezing, repetitive cough, paleness, bluish cast, faintness, weak pulse, dizziness, tightness in throat, hoarseness, trouble breathing/swallowing, significant swelling of the tongue and/or lips, multiple hives over body, widespread redness, repetitive vomiting or severe diarrhea, or a combination of mild or severe symptoms, give:

☐ Epinephrine (Given First) ☐ Antihistamine (After Epinephrine) ☐ Inhaler (After Epinephrine)

For **MILD** allergic reaction symptoms, including itchy/runny nose, sneezing, itchy mouth, few hives, mild itching, and mild nausea/discomfort, give:

☐ Antihistamine ☐ Inhaler

Medication Information – Mark All That Apply:

1 **Epinephrine Delivery Systems (able to be carried and self-administered with physician consent, must initial below):**

INJECTION (IM): ☐ Epipen JR/Auvi Q/Generic Epinephrine **0.15 mg** ☐ Epipen/Auvi Q/Generic Epinephrine **0.30 mg**

NASAL SPRAY (Intranasal): ☐ Neffy Epinephrine **1 mg** ☐ Neffy Epinephrine **2 mg**

☐ Give for known allergen exposure even if no symptoms ☐ Give for likely allergen exposure for any symptoms

☐ A second dose of epinephrine may be given 5-10 minutes after the first dose, if symptoms persist or recur.

_____ (Physician Initial) Student to **carry medication and self-administer epinephrine delivery system**. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication (epinephrine delivery system).

2 **Antihistamine given by mouth (not able to be carried or self-administered, must be in health office/with staff)**

☐ Benadryl (Diphenhydramine) ☐ Zyrtec (Cetirizine) ☐ Other Medication: _____

DOSE: _____ **FREQUENCY:** Repeat dose every _____ hours

3 **Inhaler inhaled by mouth (able to be carried and self-administered with physician consent, must initial below)**

☐ Albuterol ☐ Levalbuterol ☐ Other: _____ ☐ Use with spacer

DOSE: ☐ 2 puffs or ☐ 4 puffs or ☐ ____ puffs **FREQUENCY:** Repeat dose every _____ hours

☐ Repeat dose in 10-15 minutes if symptoms have not resolved

_____ (Physician Initial) Student to **carry medication and self-administer inhaler**. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication (Inhaler).

Additional Instructions: _____

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with states laws and regulations. Specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the credentialed school nurse.

Physician Printed Name	Physician Signature	Date
Phone	Fax	Clinic Stamp

Continue onto Page 2 for Parent/Guardian Consent. Both Physician Authorization and Parent/Guardian Consent must be completed before medication administration can begin at school.

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Medication Authorization
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Parent/Guardian Consent

I request that my child be allowed to take medication at school according to instruction from the above health care provider. I authorize school personnel to assist with this medication for my child as ordered from the above health care provider. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480).

I give consent to communication and exchange of information between PAUSD and the health care provider listed above regarding the health care provider's written statement or any other questions about the medication or medication administration.

I understand and agree to the following responsibilities regarding medication administration:

1. This form must be renewed whenever student's prescription changes and at **beginning of each school year**. Forms for the next school year must be signed after the current school year has ended.
2. Prescription medication must be in a container labeled by the pharmacist or health care provider and will not be expired.
3. Non-prescription medication must be in the original container with the label intact.
4. An adult must bring the medication to the school health office and pick up any outdated or unused medication.
5. Pill splitting must be done by parent/guardian prior to providing medication to school officials.
6. Parents/Guardians provide all materials or necessary equipment (e.g. measuring spoon) for medication administration.
7. **Students may only carry and self-administer an epinephrine delivery systems, inhaled asthma medication, or diabetes management supplies**. Exceptions to this rule will be made on a case by case basis in consultation with the Health Services Coordinator and student's physician. In order to carry and self-administer, there must be written authorization by student, parent, and health care provider.
8. Parents will notify the school and provide new written consent for any changes to the above authorization.
9. Any modifications or changes to the above authorizations may only be made after written notification is received from the health care provider.
10. I understand that 911 will be called in the event of a severe allergic reaction and/or epinephrine administration.

Parent/Guardian Signature	Date	Phone

Student and Parent/Guardian Consent to Carry and Self-Administer Epinephrine Deliverey Systems and/or Inhaler

Before student can carry and self-administer their medication, there must be written authorization from physician (initialed on page 1) along with parent/guardian and student consent below.

Parent/Guardian Consent

I give my permission for my child to carry and self-administer the above medication as directed by the HCP, which I have also signed. I agree that my child has been trained and is competent to carry and self-administer this medication. I release the school district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering the Epinephrine Auto-Injector and/or the Inhaler. I understand this permission to carry and self-administer medication may be temporarily suspended, modified, or revoked by the school district to re-evaluate for any concerns regarding safety, compliance with protocols, or if having the student carry/administer this medication creates an unsafe situation.

Parent/Guardian Signature	Date	Phone

Student Consent

I, _____, will be responsible for carrying, administering, and keeping my medication safe at all times. I know the signs and symptoms of an allergic reaction and am able to use my mediation as directed. I agree to self-administer my medication and/or manage medical equipment exactly as ordered by my health care provider. I understand that prescription medication must be in a container labeled by the pharmacist or health care provider. I understand that non-prescription medication must be in the original container with label intact. I understand that this medication/equipment is for my personal use only and must be kept in my possession. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing. I understand that I am responsible for maintaining supplies of my medication and to notify the school office if I run out of medication or supplies.

Student Signature	Date