

Life Threatening Allergy - Authorization to Administer Medication at School

Student Information

Full Name:

Date of Birth:

School:

Grade/School Year:

This section to be completed by a Licensed Health Care Provider

Date of Last Reaction:

**SEVERE
ALLERGY TO:**

Indications for Administration: ☐ Ingestion/exposure to allergen (even if no signs/symptoms of anaphylaxis are present)

☐ When/If student displays or reports signs/symptoms of anaphylaxis



LUNGS: Short of
Breath, wheeze,
cough, chest
tight/pain



HEART: Pale
skin, faint, weak
pulse, dizzy,
fast heart rate,
sweaty



THROAT:
Tight, tickle,
hoarse, trouble
swallow, drool



MOUTH:
Swelling of
tongue or lips



SKIN: Hives,
widespread
redness,
itching,
swelling



GUT: Nausea,
vomiting,
cramps, diarrhea



OTHER: Sense of doom
or something is wrong,
irritable, loss of
consciousness,
headache

Give Epinephrine & call 911, Parent Notification:

Intramuscular: ☐ 0.3 mg ☐ 0.15 mg ☐ 0.1 mg **Intranasal:** ☐ 2 mg ☐ 1 mg

Repeat Dose: ☐ No ☐ Yes in min, if available, & symptoms are not relieved/return

Authorized to self-carry/self-administer? ☐ Yes ☐ No

After Epi is given, **Antihistamine order:** ☐ Yes ☐ No

☐ Benadryl/Diphenhydramine: mg by mouth

☐ Zyrtec/Cetirizine: mg by mouth

☐ Other: : mg by mouth

Provider Notes:

Full Name:

Phone/Fax #:

Date:

Provider Signature

ORDER DURATION

- ☐ Current school year
w/ summer school
☐ Other Dates:

This section to be completed by a Parent/Guardian/18+ Student with legal decision making

Please select **ONE** of the following options:

☐ I request that authorized school personnel assist my child in taking the medication described above.

☐ I request that my child be permitted to self-carry and self-administer the specified medication, excluding controlled meds. We acknowledge the responsibility of self-management and understand the school will not monitor compliance, dosage, or expiration. I agree to indemnify and hold harmless the school and District against all claims or liabilities arising from my student's self-carry/administration of their medication.

FOR School Nurse: ☐ Approved ☐ Not Approved ☐ Review Completed w/student

Full Name:

Phone/Fax #:

Date:

Parent/Guardian Signature

☐ Student 18+ yrs signing for self

Your signature indicates that school personnel have permission to communicate with the licensed prescriber regarding use, side effects, response, and contraindications of the medication (s).

Self-Carry/Self Administer Knowledge and Responsibility

Students Authorized to Self-Carry / Self-Administer Medication(s)

The student must demonstrate competence to possess and self-administer prescribed medications during school and at school sponsored events to the School Nurse.

Student is consistently able to:

- ☐ Identify the correct medication
- ☐ Identify the purpose of the medication
- ☐ Identify specific symptoms and need for medication administration
- ☐ State the correct dosage
- ☐ State side effects/adverse reactions to this medication
- ☐ Describe what will happen if medication is not taken
- ☐ Demonstrate the correct method of administration
- ☐ Identify safety issues (i.e., no sharing of medication, safe storage, consistent placement)
- ☐ Demonstrate knowledge of how to access assistance from school staff if needed in an emergency

Full Name:

Date:

Nurse Signature

I understand that there are rules and responsibilities in self-administering my medication.

- ☐ I will keep my medication with me at all times.
- ☐ I will notify a responsible adult immediately when I use epinephrine.
- ☐ I will not share medication with any other student.
- ☐ I will not leave medication unattended where another person could access it.
- ☐ I will not use this medication for any other purpose than to treat my medical signs and symptoms.
- ☐ I understand that this is a privilege that can be changed if I do not follow the rules.

Full Name:

Date:

Student Signature