Lake Elsinore Unified School District
Health Services

Student Name	DOB	School	Grade

Parent Consent and Authorized Healthcare Provider Authorization for Administration of Epinephrine Auto-Injector (EAI) in Educational Settings and Sponsored Events

1. **Allergens or factors causing anaphylactic reaction:**
   _____
   _____

2. **Student's most common signs and symptoms:**
   _____
   _____

3. **Student's typical reaction time after allergen exposure:**
   ☐ < 10 min ☐ < 30 min ☐ < 1 hour ☐ > 1 hour

4. **History of anaphylactic reaction:** ☐ Yes ☐ No

5. **Student has asthma:** ☐ Yes ☐ No

6. **Administer Epinephrine Auto-Injector (EAI) when:**
   - ☐ **Student has <u>any</u> of the following severe symptoms after eating their allergen or being stung:**
     - Short of breath/wheezing/coughing
     - Pale/bluish color skin
     - Tight/hoarse throat
     - Trouble breathing/swallowing
     - Hives (many)/redness over body
     - Vomiting/diarrhea (combined with other symptoms)
     - Confusion/altered consciousness/agitation/feeling of impending doom
     - Weak pulse
     - Fainting/dizziness
   - ☐ **Student has <u>more than one mild</u> symptom.**
   - ☐ **Student has <u>one mild</u> symptom.**
     - Itchy nose, sneezing, itchy mouth
     - A few hives
     - Mild stomach nausea or discomfort
   - ☐ **Student has definite exposure to allergen; no immediate symptoms noted.**

7. **Medication: Epinephrine Auto-Injector (EAI) IM:**
   ☐ 0.3 mg (adult: > 66 pounds)
   ☐ 0.15 mg (junior: 33 to < 66 pounds)

8. **Administer 2nd dose 15 minutes after 1st dose if symptoms persist or recur:** ☐ Yes ☐ No

9. **Administer the following medication <u>after</u> EAI:**
   ☐ None
   ☐ Antihistamine:
   Name:_____
   Dose:_____
   Route:_____
   ☐ Inhaler-Bronchodilator:
   Name:_____
   Dose:_____
   Route:_____
   ☐ Other:
   Name:_____
   Dose:_____
   Route:_____

10. **Administer antihistamine if student has <u>one mild</u> symptom:**
    - Itchy nose, sneezing, itchy mouth
    - A few hives
    - Mild stomach nausea or discomfort

    Name:_____
    Dose:_____
    Route:_____

Authorized Health Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Authorized Healthcare Provider Name (print)_____ **NPI Number** _____

Signature _____ **Date** _____

Address_____ **Phone** _____

Parent Consent for Authorization and Management in the Educational Setting

I (we), the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical healthcare service be administered to my (our) student in accordance with state laws and regulations. I (we) will:

1. Provide the necessary supplies and equipment;
2. Notify the credentialed school nurse if there is a change in child's health status or attending authorized healthcare provider; and
3. Notify the credentialed school nurse immediately and provide new written consent/authorizations for any changes in the above authorization.

I (we) give consent for the credentialed school nurse to communicate with the authorized healthcare provider when necessary. ***If your authorized healthcare provider would like your child to carry an Auto Injector on his/her person, page 2 of this form MUST be completed by the health care provider, parent, and child.**

Parent/Guardian Signature _____ **Relationship** _____ **Date** _____

(PAGE 1 AND 2 MUST BE COMPLETED FOR SELF-ADMINISTERED MEDICATION)

Lake Elsinore Unified School District
Health Services

Student Name	DOB	School	Grade

Page 2. Permission to Carry and Self-Administer Epinephrine Auto-Injector (EPI)

In order for your child to carry a self-administered emergency medication (EPI) on his/her person, the following must be understood and agreed upon by the student and parents: the student may utilize the prescribed self-administered medication as needed and directed by his/her authorized healthcare provider. The authorized healthcare provider's signature indicates the student has been instructed on the proper use of the prescribed medication. The medication must be properly labeled with the student's name**. *Both the Authorization for Management of Epinephrine Auto-Injector (page 1) and this Protocol (page 2)*** must be signed by the parent/guardian and placed on file at the school prior to your child carrying an EPI on his/her person.

Self-administered emergency epinephrine (EPI): NO DIRECT MONITORING will be conducted by the school staff. The student is responsible for notifying school staff in the event he/she had the need to self-administer the emergency medication.

- It is the parents' responsibility to immediately notify the school if the child's health status changes, or when a change in authorized healthcare provider and/or medication occurs. Changes in procedure must be received in writing from the healthcare provider authorizing treatment.
- The district is not responsible for any risk involved with improper handling of this medication including overuse, improper administration, breakage, theft, loss, sharing, playing with or careless storage of the medication.
- Re-evaluation of the present protocol may be needed if the student is found to display behavior that increases the safety risks of him/herself or the students on campus.

TO BE COMPLETED BY AUTHORIZED HEALTHCARE PROVIDER: The above-named student has been instructed in the proper use of their epinephrine auto-injector (EPI). The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that s/he be permitted to carry the EPI at school or school sponsored events. S/he is capable of self-administering the medication, understands the purpose, appropriate method, and frequency of use of the emergency medication.

Authorized Healthcare Provider Name (print)_____ **NPI Number** _____

Signature _____ **Date** _____

Address_____ **Phone** _____

TO BE COMPLETED BY PARENT/GUARDIAN: I permit my child to carry the above-listed emergency medication as ordered by his/her authorized healthcare provider. I also specifically release the school district and all school personnel from any and all civil liability if my child suffers an adverse reaction as a result of self-administering medication during school hours.

Parent/Guardian Signature _____ **Date** _____

TO BE COMPLETED BY THE STUDENT: I have been instructed in the proper use of my medication and will take it as prescribed to me by my authorized healthcare provider. I understand that using my medication in a manner other than as prescribed by my doctor can result in disciplinary action taken against me by my school/district.

Student Signature _____ **Date** _____

REVIEWED AND APPROVED BY DISTRICT NURSE:_____ **Date:**_____

Nurse Signature

Please return the fully completed forms to your child's school health office signed by the authorized healthcare provider, parents/guardian, and student. Medication forms must be renewed at the beginning of each school year or whenever there is a change in medication or instructions.

NO MEDICATIONS WILL BE ALLOWED WITHOUT THE REQUIRED SIGNATURES