

**SEVERE ALLERGY CARE PLAN AND MEDICATION AUTHORIZATION FORM
SANTA BARBARA UNIFIED SCHOOL DISTRICT**

Student Name/Nombre del estudiante:	ID:
School:	Grade:
Allergen/symptoms:	

Parent/Guardian Contact Information/ Información de contacto del padre/madre/tutor

1.	Phone:
2	Phone:

TREATMENT PROTOCOL

1. CALL 911 AND ADMINISTER EPINEPHRINE IMMEDIATELY FOR ANY:

Difficulty breathing, gagging, repetitive cough, inability to speak	Swelling of the tongue, lips or face Tightness in the throat
Itchy or tingly mouth	Feeling faint, dizzy, lightheaded, confused
Sense of impending doom	Excessive hives
Vomiting, diarrhea, abdominal pain	

OR If ANY 2 body systems are involved even if mild (i.e. skin AND stomach)

2. MONITOR STUDENT – DO NOT LEAVE ALONE

- Monitor for breathing difficulties or changes. If breathing is difficult, allow student to sit up
- If unconscious, lay student on their side
- If stinger is present, remove stinger

3. ADMINISTER MEDICATIONS

If a medication must be taken during the school day or during a school sponsored overnight trip, it is necessary, in accordance with **California Education Code Section 49423**, to have a written statement on file.

- **ALL** prescription medications must have a completed and signed statement from **BOTH** the physician **AND** parent/guardian **BEFORE** they can be administered.
- The authorization must be made annually and/or whenever a change occurs.
- ***Medication must be provided in the original container labeled with the student's name, medication name, dose/strength and specific administration directions.***

REV: Jul-25

1

See reverse

Authorized Medications – This section to be completed by medical provider only

	Epinephrine	Antihistamine	Bronchodilator
Name of medication	1.	2.	3.
Purpose			
Strength / Dose	☐ 0.3mg ☐ 0.15mg ☐ 1mg ☐ 2mg		
Route of administration			
Frequency			
Instructions, adverse effects,	Call 911 if used		
Can Student carry and self-administer	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Repeat a second epinephrine dose (if available) after _____ minutes if the student continues to have difficulty breathing or signs and symptoms of anaphylaxis.			

Medical Provider Authorization: As the Medical Provider of the above-named child, it is, in my professional opinion, appropriate and necessary that the above medications be available for administration during the school day, or during extended hours when the child is on school sponsored trips/outings/events.

Medical Provider Printed Name (or stamp): _____

Medical Provider Signature: _____ **Date:** _____

Autorización del padre/madre/tutor:

Como padre/madre/tutor del estudiante mencionado anteriormente, solicito que el personal escolar indicado ayude en la administración de los medicamentos recetados por el proveedor médico. Doy mi consentimiento para que el proveedor de servicios médicos y el personal escolar indicado se comuniquen directamente con respecto a la administración del medicamento. Entiendo que es mi responsabilidad llevar todos los medicamentos de manera segura a la escuela y acepto reabastecer o reemplazar los medicamentos según sea necesario. Entiendo que el medicamento se almacenará en un área cerrada a menos que el proveedor médico indique que mi hijo es capaz de llevarlo consigo y autoadministrarse. Por la presente, eximo al Distrito Escolar Unificado de Santa Bárbara y a todo el personal de la escuela de responsabilidad civil si mi hijo sufre una reacción adversa como resultado de la administración de epinefrina autoinyectable recetada o medicamentos inhalados recetados para el asma.

Parent/Guardian signature: _____ **Date:** _____

Student Statement (required if authorized to self-carry medication) I understand that I am allowed to carry and self-administer ONLY the medications listed above. I agree to use the medication as instructed by my physician and not to share with other people. I understand that if I share the medication with others, I will be held accountable for my actions and that I will face disciplinary action.

If I self-administer epinephrine, I will notify Health Office staff immediately.

Signature of Student: _____ **Date:** _____