



Authorization for Administration of Epi-Pen/Antihistamine at School

Student Name: _____ Birth Date: _____ Sex: M / F
School: _____ Teacher: _____ Grade: _____

ANAPHYLAXIS ALLERGY TO: _____

OTHER ALLERGIES TO: _____

Has the student had a previous anaphylactic reaction requiring the use of an Epi-Pen? Yes* No

(* If yes, in the event of an allergen exposure or potential exposure, school staff will immediately administer the epi pen and call 911)

Does the student also have asthma? Yes * No (*Yes, means there is a higher risk for severe reaction)

Is there an Inhaler Prescribed? Yes No

HEALTH CARE PROVIDER completes this section: *(please print)*

Antihistamine: _____ **Dose:** _____

☐ Tablet/Capsule ☐ Liquid ☐ Other _____

How soon can it be repeated? _____

Diagnosis/ Reason for Medication: _____

Significant Side Effects: _____

Epi-Pen: ☐ 0.15mg (JR) ☐ 0.30mg

Repeat Dose? ☐ Yes ☐ No **When to Repeat?** _____

Child may carry and self-administer Epi-Pen ☐ Yes ☐ No

Diagnosis/ Reason for Medication: _____

Significant Side Effects: _____

Indications for Administration of Epi-Pen/Antihistamine:

Mild Symptoms:

Mouth: Itching, tingling, or mild swelling of the lips

Skin: Mild itchy, few hives, and/or rash

Nose: Itchy or runny nose, sneezing

GI: Mild nausea and/or abdominal cramps

Severe Symptoms:

Lungs: Shortness of breath, repetitive coughing, or wheezing

Throat: Tightening of throat, hoarseness, or hacking cough

Heart: Weak pulse, low blood pressure, fainting, pale or blue

Mouth: Significant swelling of tongue or lips

Skin: Severe hives or redness

GI: Significant nausea, repetitive vomiting or severe diarrhea

Other: Anxiety, confusion, or feeling like something bad will happen

Give Checked Medications (please check only one):

☐ Epi pen ☐ Antihistamine

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Give Checked Medications (please check only one):

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Care Provider Signature: _____ **Date:** _____

Print Name: _____ **Phone #:** _____ **Fax #:** _____

PARENT/GUARDIAN completes this section:

If your child has a reaction and his/her Epi-Pen is unavailable, does the school have permission to use a stock Epi-Pen?

☐ Yes ☐ No

I request that my child be allowed to take the medication as described above. I will provide the medication in the original, properly labeled container. I understand that if I do not pick up any medication left at the end of the school year, it will be destroyed. I give my permission for school staff to communicate freely with this health care provider. I understand that my signature indicates my understanding that the school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and in accordance with the District Policy and Procedure 3416 and 3416P.

Parent/Guardian Signature: _____ Date: _____

Daytime Phone: _____ Emergency Phone: _____

Reviewed by School Nurse: _____ **Date:** _____

Reviewed by District Nurse: _____ **Date:** _____

Mailing Address:
Lakewood School District #306
P.O. Box 220 N. Lakewood, WA 98259
School District Fax #: 360-652-4502
School Building Fax #: _____