MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

School District: Coulee-Hartline SD School: Almira Coulee-Hartline High, Coulee City Elementary FAX: (509)632-5166

Student:_____ Birth Date:_____ Grade:_____

Parent Section *Seccion des Padres*

I request that the school nurse, or designated staff member, administer the following medication in accordance with healthcare provider instructions. *Yo pido que la enfermera o personal designado le adminstre el medicamento recetado de acuerdo con las instrucciones del medico.*

I give my permission for the medication information to be shared with school staff on a "need to know basis." ☐ Yes/*si* ☐ No
Doy permiso que la siguiente informacion sea compartida con el personal escolar que necesite estar informado

I give permission for my child to carry this emergency medication. ☐ Yes/*si* ☐ No
Doy permiso para que mi estudiante pueda cargar su medicamento de emergencia

I give permission for my child to self-administer this emergency medication. ☐ Yes/*si* ☐ No
Doy permiso para que mi estudiante pueda administrarse su propio medicamento de emergencia

_____ _____ _____ _____
Signature/Firma *Date/Fecha* *Phone #1 Numeros de telefoonas* *Phone #2*

LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW

Student has severe allergy to: _____

Describe symptoms in previous reactions: _____

_____

Student also has asthma? ☐ No ☐ Yes (Together they increase adverse outcome risk)

Complete Box 1 (required for all students) and if appropriate, Box 2.

☐ 1) Treatment for Exposure to Allergen/Suspected Exposure OR Serious Symptoms

Exposure/Suspected Exposure
OR
Serious Symptoms:

Skin: hives, swelling in areas other than allergen contact area.
Mouth: itching, swelling of lips, tongue or mouth.
Throat: itching, sense of tightness, hoarseness,.
Lungs: significant shortness of breath, repetitive coughing, wheezing.
Gut: nausea, cramps, vomiting, and/or diarrhea.
Heart: lightheadedness; dizziness; passing out

1. **Give Epinephrine IM Immediately**
   - ☐ Epinephrine auto-injector 0.15mg
   - ☐ Epinephrine auto-injector 0.3mg

   If symptoms continue, repeat Epinephrine after _____ minutes.
   (If repeat dose ordered, please provide school with 2nd dose.)
2. Note time given.
3. Call 911. Ask for Advanced Life Support for an allergic reaction.
4. Call parent/guardian.
5. Remain with student until EMS arrives.

☐ 2) Optional Treatment for No Known Exposure WITH Mild Symptoms

No Known Exposure
WITH
Mild Symptoms (please check):

☐ Localized hives
☐ Localized swelling
☐ Other (describe)_____
_____
_____

☐ Notify parent/guardian to pick up student for observation.

OR

☐ 1. Give Antihistamine. (Specify medication/dose/frequency)

_____

2. Notify parent/guardian antihistamine has been given and to pick student up for further observation.

If serious symptoms develop, give Epinephrine as instructed in Box 1 above.

This student may carry this emergency medication at school. ☐ Yes ☐ No
This student is trained and capable to self-administer this emergency medication. ☐ Yes ☐ No

Medication order is valid for duration of current school year (which includes summer school).

_____ _____
Licensed Health Care Provider Signature *Printed LHCP Name*

_____ _____ _____
Date *Health care provider phone* *Health care provider FAX*