

MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

OTHELLO SCHOOL DISTRICT, School: _____
 Registered Nurse Contact Numbers: 509-488-3351 EXT 2029 and 2015



Student: _____ Birth Date: _____ Grade: _____

Parent Section	I request that the school nurse, or designated staff member, administer the medication prescribed below, in accordance with the healthcare provider instructions. I understand that this information will be shared with school staff on a "need to know" basis. <i>Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del médico.</i> <i>Yo entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.</i>
Sección de Padres	I give permission for my child to carry this medication. <input type="checkbox"/> Yes/ Sí <input type="checkbox"/> No <i>Doy permiso para que mi hijo/hija pueda cargar su medicamento.</i> I give permission for my child to self-administer this medication. <input type="checkbox"/> Yes/ Sí <input type="checkbox"/> No <i>Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.</i> I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No <i>Doy permiso para la enfermera de iniciar un plan 504. (Ver formulario adjunto)</i>
_____ Signatura/Firma Date/Fecha Phone #1 Números de teléfonos 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
 If yes, rescue inhaler may be used **after** the Epinephrine has been given: Yes No

REQUIRED

Treatment for Exposure to Allergen/Suspected Exposure OR Serious Symptoms

<p>Exposure/Suspected Exposure OR Serious Symptoms:</p> <ul style="list-style-type: none"> • Hives or swelling in areas other than allergen contact area • Itching, swelling of lips, tongue, throat, or mouth • Sense of tightness in throat, hoarseness • Significant shortness of breath, repetitive coughing, wheezing • Nausea, cramps, vomiting, and/or diarrhea • Lightheadedness; dizziness; passing out 	<p>1. Give Epinephrine IM Immediately (side effects: <input type="checkbox"/> HR, nervousness)</p> <p>Epinephrine auto-injector: <input type="checkbox"/> 0.15mg OR <input type="checkbox"/> 0.3mg</p> <p><input type="checkbox"/> If symptoms continue, repeat Epinephrine after 5 - 10 minutes. <i>(If repeat dose ordered, please provide school with 2nd dose.)</i></p> <p>Optional:</p> <p><input type="checkbox"/> After giving epinephrine, give ____mg antihistamine <i>specify medication: _____</i></p> <p>2. Note time medication was given 3. Call 911, ask for Advanced Life Support for an allergic reaction 4. Call School Nurse (if available) and notify parent/guardian 5. Remain with student until EMS arrives. Student should be lying down</p>
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OPTIONAL: This student has an additional mild allergy to: _____

Treatment for No Known or Suspected Exposure to Life-Threatening Allergen WITH ONLY Mild Symptoms

<p>No Known or Suspected Exposure to Life-Threatening Allergen and ONLY A few localized hives.</p> <p><i>Common side effects of antihistamine include drowsiness, dry mouth and constipation.</i></p>	<p><input type="checkbox"/> Notify parent/guardian to pick up student for observation</p> <p>OR</p> <p><input type="checkbox"/> 1. Give ____mg antihistamine <i>specify medication: _____</i></p> <p>2. Notify parent/guardian that antihistamine was given and to pick student up for further observation.</p> <p><input type="checkbox"/> If any serious symptom develops, give Epinephrine as instructed above.</p>
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This student may carry this emergency medication at school and on the bus 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