



MEDICAL AUTHORIZATION FOR ALLERGY MANAGEMENT AT SCHOOL

Thorp School District Phone: 509-964-2107 Fax: 509-964-2313

Student: _____ Birthdate: ____/____/____ Grade: _____

Parent Section <small>Sección de Padres</small>	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. Yo entiendo que cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.</i>		
	I give permission for my child to carry this medication. <i>Doy permiso para que mi hijo/hija pueda cargar su medicamento.</i>	<input type="checkbox"/> Yes/ Sí	<input type="checkbox"/> No
	I give permission for my child to self-administer this medication. <i>Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.</i>	<input type="checkbox"/> Yes/ Sí	<input type="checkbox"/> No
	I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) <i>Doy permiso para la enfermera de iniciar un plan 504. (Ver formulario adjunto)</i>	<input type="checkbox"/> Yes/Sí	<input type="checkbox"/> No
_____ Parent/Guardian Signature/Firma		_____ Parent/Guardian Printed Name	_____ Date/Fecha
_____ Phone Número de teléfono			

LICENSED HEALTHCARE PROVIDER (HCP) 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 SECTION

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 	<ol style="list-style-type: none"> 1. Give Epinephrine IM Immediately (<i>side effects: HR, nervousness</i>) Epinephrine auto-injector: <input type="checkbox"/> 0.15mg OR <input type="checkbox"/> 0.3mg <input type="checkbox"/> If symptoms continue, repeat Epinephrine after 5 - 10 minutes. <i>(If repeat dose ordered, please provide school with 2nd dose.)</i> Optional: <input type="checkbox"/> After giving epinephrine, give _____ mg antihistamine <i>specify medication:</i> _____ 2. Note time 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.
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OPTIONAL SECTION

Treatment for No Known/Suspected Exposure to Life-Threatening Allergen with ONLY Mild Symptoms

<p>No known/suspected exposure to life-threatening allergen and ONLY mild symptoms</p> <p><input type="checkbox"/> A few localized hives</p> <p><input type="checkbox"/> Other: _____</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 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 a 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 the duration of the current school year, which includes summer school.

HCP Signature

HCP Printed Name

Date

HCP Phone

HCP FAX