MEDICAL AUTHORIZATION FOR SEVERE ALLERGY MANAGEMENT AT SCHOOL

West Valley School District West Valley High School Phone: (509) 972-5629 FAX: (509) 972-5901

Student:____ **Birth Date:**____________________ **Grade:**_______

Parent Section *Sección de Padres*

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.
Yo pido que la enfermera o personal designado, le administre el medicamento recetado de acuerdo con las instrucciones del médico. Yo entiendo cualquier información de este formulario será comunicada al personal escolar que necesite estar informado.

I give permission for my child to carry this medication. ☐ Yes/ *Sí* ☐ No
Doy permiso para que mi hijo/hija pueda cargar su medicamento.

I give permission for my child to self-administer this medication. ☐ Yes/ *Sí* ☐ No
Doy permiso para que mi hijo/hija pueda administrarse su propio medicamento.

I give permission for the nurse to initiate a 504 plan. (See Parent and Student Rights Attached) ☐ Yes/*Sí* ☐ No
Doy permiso para la enfermera de iniciar un plan 504. (Ver formulario adjunto)

____________________ __________ ______________ ______________
Signature/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*

Exposure/Suspected Exposure **OR** **Serious Symptoms**: • 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	1. **Give Epinephrine IM Immediately** *(side effects: ↑ HR, nervousness)* Epinephrine auto-injector: ☐ 0.15mg OR ☐ 0.3mg ☐ If symptoms continue, repeat Epinephrine after 5 - 10 minutes. *(If repeat dose ordered, please provide school with 2nd dose.)* *Optional:* ☐ **After** giving epinephrine, give ____mg antihistamine *specify medication:*____________________ 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

OPTIONAL: This student has an additional mild allergy(ies) to____________________________________

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

No Known or Suspected Exposure to Life-Threatening Allergen and **ONLY** **A few localized hives.** *Common side effects of antihistamine include drowsiness, dry mouth and constipation.*	☐ Notify parent/guardian to pick up student for observation **OR** ☐ 1. Give ______ mg antihistamine *specify medication:*____________________ 2. Notify parent/guardian that antihistamine was given and to pick student up for further observation. ☐ **If any serious symptom develops, give Epinephrine as instructed above.**

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*