HOME OF THE BLAZERS

AUTHORIZATION FOR ANAPHYLAXIS MEDICATION AT SCHOOL
(MUST BE SIGNED BY LICENSED HEALTH CARE PROVIDER AND PARENT/LEGAL GUARDIAN)

School Year:_____

Please Print

Student's Name:_____Birthdate:_____

Student is SEVERELY allergic to:

_____

Medication to be administered at school:

- ☐ **Antihistamine dose: _____Route: Oral____**
- ☐ **Epinephrine Auto Injector dose: ▢ 0.15mg ▢ 0.30mg to be given intramuscularly**
- ☐ **Epinephrine Nasal Spray dose: ▢ 1mg ▢ 2mg to be given intranasally**
- ☐ **Other:_____**

Licensed Health Care Provider specific instructions for medication administration (example: give antihistamine prior to epinephrine):

_____

Student's first symptoms may start as (check all that apply):

- ▢ **Itching and swelling of the lips, tongue or mouth**
- ▢ **Hives, itchy rash and/or swelling around the face or extremities**
- ▢ **Itching and/or a sense of tightness in the throat, Hoarseness and hacking cough**
- ▢ **Nausea, abdominal cramps, vomiting and/or diarrhea**
- ▢ **Shortness of breath, repetitive coughing and/or wheezing**
- ▢ **"Thready" pulse or passing out**

Self-Carry/Self-Monitor:
The student has orders from a licensed health care provider to self-carry/self-monitor this medication.
▢ Yes ▢ No

This student is to self-administer and self-monitor this medication while at school. Training has been completed by the licensed health care provider and the student has demonstrated competency in self-monitoring and self-administration of this medication. Medication must be with the student during school sponsored activities, in transit to and from school sponsored activities and during, before or after-school activities on school property. The parent is aware that they cannot hold the school responsible for any adverse outcome of this action.

Printed Name of Licensed Health Care Provider:_____Phone:_____

Licensed Health Care Provider Signature:_____Date:_____
(By signing this form, I am verifying that I have assessed this child and agree with the above treatment.)

This form is only valid if signed on or after July 1st for the upcoming school year.*

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Student Name:_____

Field Trips: **(The school will provide training for staff at the school to assist your child if needed).**

- ☐ **The student has permission from the physician to self carry and self monitor the medication and will be responsible for having medication available for trips off campus.**
- ☐ **The teacher in charge of the field trip will additionally be trained and have responsibility for administering medication if needed.**

Bus Transportation:

- ☐ **Yes, The student must have his/her anaphylaxis medication available on the bus.**
- ☐ **No, The student does not need his/her anaphylaxis medication available on the bus.**

Parent/legal guardian please read carefully and sign below if you agree to the following:

- ❖ **I understand that all medication will be provided by me in the original container, clearly labeled by the pharmacy with my child's name.**
- ❖ **I will provide all necessary supplies/medication and notify the school of changes in condition or prescribed treatment plan. *I will notify the school if the medication is discontinued or the dosage has been changed.***
- ❖ **Permission is granted to the principal/and or school nurse to share this information with individuals who have responsibility for my child.**
- ❖ **I give the school nurse and/or designee permission to contact the licensed health care provider's office to request medical information concerning my child.**
- ❖ **I am responsible for replacing medication before the expiration date.**
- ❖ **If the licensed health care provider authorizes my child to carry his/her medication during the school day, I understand that I cannot hold the school responsible for any adverse outcome of this action.**
- ❖ **The school is not liable for any injury arising from administration of medication authorized by an IHP(Individual Health Plan) or licensed health care provider. As a parent/guardian, I shall indemnify and hold harmless the school against a claim arising from administration of medication authorized by an IHP or licensed health care provider.**

- ☐ **My student has orders from the licensed health care provider to self carry or self monitor this medication.**
- ☐ **My student has been trained by the licensed health care provider and has demonstrated competency.**

Parent/legal guardian signature:_____**Date:**_____

Parent/Guardian Printed Name:_____ **Phone:**_____

Please do not hesitate to administer medication or call 911.
Alert EMS to possible allergic reaction.

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