Annual Health Services Prescription
Physician/Parent Authorization for Anaphylaxis Management

* This form is to be renewed at the beginning of each school year
For children with multiple severe allergies, use one form for each allergy.

ALLERGY TO: _____

Student name: _____ Grade: _____ DOB: _____

Parent name: _____ Phone (H): _____ (W) _____

Physician name: _____ Phone: _____ Hospital: _____

Asthmatic? Yes (High risk for severe reaction) ☐ No ☐

Systems	Possible Symptoms:
MOUTH	*itching & swelling of the lips, tongue, or mouth*
*THROAT**	*itching and/or sense of tightness in the throat, hoarseness, & hacking cough*
SKIN	*hives, itchy rash, &/or swelling about the face or extremities*
ABDOMIN	*nausea, abdominal cramps, vomiting, &/or diarrhea*
*LUNG**	*shortness of breath, repetitive coughing, &/or wheezing*
*HEART**	*"thready" pulse, "passing-out"*

The severity of symptoms can quickly change. ***All above symptoms can potentially progress to a life-threatening situation.* Do not hesitate to call 9-1-1!**

TO BE COMPLETED BY THE PHYSICIAN

The parent/guardian of the above named student has notified the school that this student has a potentially life-threatening allergy and will require oral medication or an EpiPen® at school, in the event of an emergency. Please complete this form based on your records and knowledge of this student and sign in the space provided.

Action Plan for Known/Suspected Sting (Bite)/Ingestion/Inhalation

Parent must provide any medication needed for anaphylaxis management: Location of medication:

☐ ACTION FOR MINOR REACTION ☐

Probable symptoms for this student include_____

1) Administer _____
Medication/dose/route

2) Contact Parents or emergency contacts.

*If condition does not improve within 10 minutes, follow steps for Major Reaction below.

☐ ACTION FOR MAJOR REACTION ☐

Probable symptoms include_____

1) **IMMEDIATELY!** Administer _____
Medication/dose/route

2) Call 9-1-1 & tell them it is life-threatening.
3) Contact Parents or emergency contacts.
4) Contact Physician.

FOR SELF-ADMINISTRATION ONLY

Does this student have physician permission to self-administer this medication and to carry this medication on himself/herself? Yes___ No____
Has this student been trained in the signs and symptoms of minor and major reactions? Yes ____ No____
Is this student capable of self-administering EpiPen®? Yes___ No___
Can this be safely self-administered in the school setting? Yes___ No___
Does this student need the supervision of a designated adult? Yes___ No___
Has the student been trained in the self-administration of the EpiPen®? Yes___ No__

Physician's Signature: _____
Date :_____Physician's Name:_____
Phone:_____ Address_____ Fax_____

To be completed by the parent

Location of oral medication :_____ Location of EpiPen®: _____

I, the undersigned, parent/guardian of _____ request that an oral medication or EpiPen® be administered to my child, as prescribed by the physician. I understand that the school administration will designate trained staff to perform this procedure. It is my understanding that in performance of the procedure, the designated person(s) will be using a standardized procedure that has been approved by the physician. I will notify the school immediately if the health status of my child changes, I change physicians, or the procedure is canceled or changed in any way. I also give my consent to release medical/health records and permission for appropriate school staff to contact the physician/health care provider for additional information if needed.

Parent's Signature: _____ Date:_____

FOR SELF-ADMINISTRATION ONLY

I, the parent/guardian of _____ request that he/she be allowed to self-administer the oral medication or I understand that the school administration will designate trained staff to monitor the procedure. It is my understanding that in performing this procedure my child will be using a standardized procedure that has been approved by the physician.
Parent's Signature: _____ Date:_____

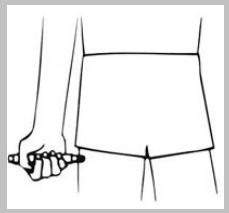
EMERGENCY CONTACTS

1. _____ Relation: _____ Daytime phone _____
2. _____ Relation: _____ Daytime phone _____
3. _____ Relation: _____ Daytime phone _____

FOR OFFICE USE ONLY

How to Use an Epinephrine Auto-Injector

1. Pull off gray safety cap
2. Place black tip on outer thigh (always apply to thigh)



3. Using a swing and jab motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10.
4. Remove and bend needle back on hard surface. Place back in plastic tube and send EpiPen ® with patient to hospital.

MEMBERS

1. _____
2. _____
3. _____