SEVERE ALLERGY CARE PLAN AND MEDICATION AUTHORIZATION FORM

Full Name: _____ Birthdate: _____
Last *First* *M.I.*

School Name: _____ School Year: _____ Grade: _____

Step 1: Identification of allergen- This section to be completed by Medical Provider.

Severe Allergy to: _____

Previous: Symptoms (if known): _____

Step 2: Treatment Protocol- This section to be completed by Medical Provider only.

Severe Symptoms

If any of the following severe symptoms are noted

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Significant swelling of the tongue and/or lips.
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting or severe diarrhea
OTHER: Feeling something bad is about to happen, Confusion, anxiety

1. INJECT EPINEPHRINE IMMEDIATELY

2. CALL 911

3. GIVE ADDITIONAL MEDICATIONS (IF ORDERED BY PHYSICIAN)

4. Lay student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side. **For insect stings/bites only: remove stinger if present.**

5. Notify emergency contacts on page 2.

Mild Symptoms

If the following symptoms are noted, give medication indicated. (Orders below)

THROAT: hoarse, persistent cough	☐ Epi-pen	☐ Antihistamine
MOUTH: Itchy or tingling mouth	☐ Epi-pen	☐ Antihistamine
SKIN: A few hives/rash, mild itch	☐ Epi-pen	☐ Antihistamine
GUT: Mild nausea/discomfort	☐ Epi-pen	☐ Antihistamine
OTHER: _____	☐ Epi-pen	☐ Antihistamine

1. GIVE medication indicated. See below.

2. Stay with student, alert emergency contacts.

3. Watch student closely for changes. If symptoms worsen, or severe symptoms appear, **GIVE EPINEPHRINE and refer to treatment protocol above for severe symptoms.**

4. If an epi-pen is administered, call 911.

☐ If checked, give epinephrine immediately for ANY symptoms if the student was *likely* exposed to the allergen/sting.
☐ If checked, give epinephrine immediately if the student was *definitely* exposed to the allergen/sting, even if no symptoms are noted.

Step 3: Authorized Medications- This section to be completed Medical Provider only.

	Epinephrine Auto injector	Antihistamine	Bronchodilator
Name of Medication	1.	2.	3.
Purpose			
Strength	☐ 0.3mg ☐ 0.15mg		
Medication Form	Auto-injector		
Route of Admin	Injected intramuscularly into lateral thigh		
Scheduled admin Or frequency if PRN			
Precautions, instructions, Adverse effects or comments			
Can the student carry and self-administer medication?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medical Provider Authorization: As the Medical Provider of the above named child, it is, in my professional opinion appropriate and necessary that the above medications be available for administration during the school day or during extended hours when the child is on school sponsored trips/outings/events.

Medical Provider Signature: _____ **Date:** _____

 (See other side)

Step 4: Parent/Guardian to complete

Emergency Contacts: **Relationship:** **Cell phone:** **Other phone:**

1. _____

2._____

3._____

Child's Physician Name: _____ **Office phone number**:_____

If a medication must be taken during the school day or during a school sponsored overnight trip, it is necessary, in accordance with **California Education Code Section 49423**, to have a written statement on file. The statement must be signed by the parent/guardian and the physician indicating a desire that designated school personnel assist the student with medication administration. **The authorization must be made annually and/or whenever a change occurs.** Education Code requires that **ALL** medications, prescription and over-the-counter must have a completed statement from **BOTH** the physician **AND** parent/guardian **BEFORE** they can be administered. Medication must be provided in the original container labeled with student's name, medication name, dose/strength and specific administration directions.

Parent/Guardian Authorization:

As the parent/guardian of the above named child, I request that designated school personnel assist in the administration of medication prescribed by the Medical Provider. I give consent for the Medical Provider and designated school personnel to communicate directly, regarding the administration of the medication. I understand it is my responsibility to bring all medication safely to the school and I agree to refill or replace medication as necessary. I understand that the medication will be stored in a locked area unless the Medical Provider indicates that my child is capable of carrying and self-administering it. I hereby release the school district and all school personnel from civil liability if my child suffers an adverse reaction as the result of self-administering prescription auto-injectable epinephrine or prescription inhaled asthma medication.

Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____ **Date**:_____

Student Statement (required if authorized to self-carry medication)

I understand that I am allowed to carry and self-administer ONLY the medications listed above. I agree to use the medication as instructed by my physician and not to share with other people. I understand that if I share the medication with others, I will be held accountable for my actions and that I will face disciplinary action.

Signature of Student: _____ **Date:** _____

How to administer Epi-Pen autoinjector