MED-6 rev 2010

ANAPHYLAXIS MEDICATION AUTHORIZATION

Must be completed by legal guardian and physician
before medication can be brought to school

SCHOOL YEAR: _____

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ PHONE #: _____

CHILD IS SEVERELY ALLERGIC TO: _____

NAME OF MEDICATION TO BE GIVEN AT SCHOOL

_____

AMOUNT OF MEDICATION TO BE GIVEN: _____

EXPIRATION DATE OF MEDICATION: _____

PHYSICIAN'S SPECIFIC INSTRUCTIONS FOR MEDICATION ADMINISTRATION:

_____

_____

CHILD IS ASTHMATIC ☐ YES ☐ NO

CHILD IS AT HIGH RISK FOR SEVERE REACTION. ☐ YES ☐ NO

CHILD'S FIRST SYMPTOMS MAY START AS: (check all that apply)

- ☐ Itching & swelling of the lips, Tongue or mouth
- ☐ Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- ☐ Hives, itchy rash, and/or swelling about the face or extremities
- ☐ Nausea, abdominal cramps, vomiting, and/or diarrhea
- ☐ Shortness of breath, repetitive coughing, and/or wheezing
- ☐ "Thready" pulse, "Passing out"

CALL **RESCUE SQUAD** (request Epinephrine)

CALL MOTHER AT: _____

CALL FATHER AT: _____

PHYSICIAN'S NAME: _____ OFFICE PHONE: _____

CHILD MUST CARRY MEDICATION. ☐ YES ☐ NO

PARENT AND PHYSICIAN MUST SIGN BOTH BOXES ON SECOND PAGE

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911.
EVEN IF PARENTS CAN NOT BE REACHED.

EMERGENY CONTACTS:

NAME: _____ DAY TIME PHONE: _____

NAME: _____ DAY TIME PHONE: _____

THE SCHOOL DISTRICT WILL PROVIDE TRAINING FOR STAFF MEMBERS AT THE SCHOOL TO ASSIST YOUR CHILD IF NEEDED.

FIELD TRIPS:

☐ I will accompany my child on all field trips away from school and assume responsibility for administering medication if needed

OR

☐ The teacher in charge of the field trip will be trained and have responsibility for administering medication if needed.

BUS TRANSPORTATION:

☐ **YES** ☐ **NO** Bus driver will be informed of my child's condition.

LEGAL GUARDIAN WILL PROVIDE ALL NECESSARY SUPPLIES AND MEDICATIONS AND WILL NOTIFY THE SCHOOL NURSE IMMEDIATELY OF ANY CHANGE IN CONDITION OR PRESCRIBED TREATMENT PLAN.

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. 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 my permission to contact my child's physician's office to request medical information concerning my child. I am aware of the expiration date and will replace medication before it expires. If our physician authorizes my child to carry his/her medication during the school day, I understand that I can not hold the school district responsible for any adverse outcome of this action.

LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

I HAVE SEEN THIS CHILD AND AGREE WITH THE ABOVE TREATMENT:

PHYSICIAN'S SIGNATURE: _____ DATE: _____

BOTH AREAS MUST BE COMPLETED IF MEDICATION IS TO BE SELF-ADMINISTERED

☐ THIS STUDENT IS TO SELF-ADMINISTER AND SELF-MONITOR THIS MEDICATION WHILE AT SCHOOL. TRAINING HAS BEEN COMPLETED BY THE PHYSICIAN AND THIS STUDENT HAS DEMONSTRATED COMPETENCY IN SELF-MONITORING AND SELF-ADMINSTRATION OF THIS MEDICATION. MEDICATION MUST BE WITH STUDENT DURING CLASSTIME AND ANY SCHOOL SPONSORED ACTIVITY. THE PARENT IS AWARE THAT THEY CAN NOT HOLD THE SCHOOL DISTRICT RESPONSIBLE FOR ANY ADVERSE OUTCOME OF THIS ACTION.

LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____