## STUDENT ALLERGY FORM:

**(Complete entire form in ink and in print)**

Today's Date: ______________________________

Child's Name: ______________________________ DOB: _____________ Teacher/Grade: ___________

Allergy to: (list all) ____________________________________________________________

Asthmatic: _______________ YES***(Higher Risk for Severe Reaction)** ____________ NO

**STEP 1: TREATMENT:**

| Symptoms: | Administer Checked Medication **(To be determined by physician authorizing treatment)** | |
|---|---|---|
| • If a food allergen has been ingested, but *no symptoms* | ____ Epinephrine | ____Antihistamine |
| • Mouth – Itching, tingling, or swelling of lips tongue, mouth | ____ Epinephrine | ____Antihistamine |
| • Skin – Hives, itchy rash, swelling of the face or extremities | ____ Epinephrine | ____Antihistamine |
| • Gut – Nausea, abdominal cramps, vomiting, diarrhea | ____ Epinephrine | ____Antihistamine |
| • Throat - Tightening of throat, hoarseness, hacking cough | ____ Epinephrine | ____Antihistamine |
| • Lung – Shortness of breath, repetitive coughing, wheezing | ____ Epinephrine | ____Antihistamine |
| • Heart – Thready pulse, low blood pressure, fainting, pale, blueness | ____ Epinephrine | ____Antihistamine |
| • Other ______________________________ | ____ Epinephrine | ____Antihistamine |
| • If reaction is progressing (several of the above areas affected) | ____ Epinephrine | ____Antihistamine |

Dosage:

Epinephrine: inject intramuscularly (circle one) – EpiPen® EpiPen Jr.® Twinject™ 0.3mg Twinject™ 0.15mg

Antihistamine: Give: ____________________________________________________________

(medication/dose/route)

Other: Give: ____________________________________________________________

(medication/dose/route)

**STEP 2: EMERGENCY CALLS:**

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Dr. ______________________________ at ______________________________
3. Emergency Contacts:

| Name/Relationship | Phone Number | Phone Number |
|---|---|---|
| 1. ____________________ | ____________________ | ____________________ |
| 2. ____________________ | ____________________ | ____________________ |
| 3. ____________________ | ____________________ | ____________________ |

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY**

Parent Signature: ______________________________ Date: ____________________

Doctor's Signature: ______________________________ Date: ____________________

## AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

**(Complete entire form in ink and in print)**

Today's Date: ______________________________________

Child's Name: ______________________________________ DOB: ________________________________

Name of Medication:__________________________________ Expiration Date: _______________________

Date medication begins: ______________________________ Date Medication Ends: __________________

Does medication need to be refrigerated? ______ YES ______NO

What is medication for? _________________________________________________________________

**Instructions for administering medication:**

Dosage/Amount ___________________________________

Form of administration: (i.e. oral, topical, injection) ______________________________________________

Time of administration: (Choose appropriate)

- ☐ At set times of day – specify time and AM or PM ______________________________________
- ☐ Only when symptoms occur – please describe _________________________________________
- ☐ In an emergency – such as with allergic reaction _______________________________________

Special administration instructions (i.e. take with food, avoid taking with certain foods)

_____________________________________________________________________________________

Possible side effects to watch for:

_____________________________________________________________________________________

Possible complications and treatment:

_____________________________________________________________________________________

Please note approximate time for medication to take effect: _____________________________________

Doctor's Name:__________________________________________ Phone: __________________________

Doctor's Address: _______________________________________________________________________

*****Attach additional instructions from doctor or pharmacist as necessary*****

Parent/Guardian Name (Printed):__________________________________ Phone: ___________________

Parent/Guardian Signature: ______________________________________ Date: ____________________

If not parent, relationship to child: _________________________________

***No student will be allowed to carry or dispense medication on their own. ALL medication must be delivered by a parent to the school office in the original container with the child's name on the container and this permission form accompanying it that gives specific instruction for administering. ALL remaining medication MUST be picked up by parents at the end of the year or it will be destroyed. This includes Epi-Pens and inhalers.***

# AUTHORIZATION TO ADMINISTER OTC MEDICATION

**(Complete entire form in ink and in print)**

Today's Date: ______________________________________

Child's Name: ______________________________________ Teacher/Grade: ________________________

Name of Medication: ________________________________

Does medication need to be refrigerated? ______ YES ______ NO

What is medication for? __________________________________________________________________________

**Instructions for administering medication:**

Dosage/Amount: ___________________________________

Form of administration: (i.e. oral, topical, injection) _____________________________________________

Time medication last administered today: ______________ AM PM

Time of administration: (Choose appropriate)

- ☐ At set times of day – specify time and AM or PM ________________________________________
- ☐ Only when symptoms occur – please describe ____________________________________________
- ☐ In an emergency – such as with allergic reaction ________________________________________

***(Parents will be contacted to verify time of AM dose given at home before first dose is given at school.)***

Special administration instructions (i.e. take with food, avoid taking with certain foods)

_____________________________________________________________________________________________

Possible side effects to watch for:

_____________________________________________________________________________________________

Parent/Guardian Name (Printed): ________________________________________

Parent/Guardian Signature: ____________________________________________ Date: ___________________

If not parent, relationship to child: ________________________________________

***No student will be allowed to carry or dispense medication on their own. <u>ALL</u> medication must be delivered by a parent to the school office in the <u>original container</u> and this permission form accompanying it that gives specific instruction for administering. OTC medication may remain locked in the nurse's office during the school year. Parents will be contacted when medication has expired or needs to be replaced. <u>ALL</u> medication must be picked up at the end of the school year or it will be destroyed.***