# MEDICATION AUTHORIZATION ORDER FOR LIFE-THREATENING ALLERGY

| Student name: | DOB: |
|---|---|
| School: | Grade: |

## THIS PORTION TO BE COMPLETED BY LHCP

**LIFE-THREATENING ALLERGY TO:**

**Asthma:** ❑ Yes ❑ No **Other Allergies:**

## SIGNS OF ANAPHYLAXIS (severe allergic reaction)

| | | | |
|---|---|---|---|
| **MOUTH** | Itching, tingling, or swelling of the lips, tongue, or mouth | **LUNG** | Shortness of breath, repetitive coughing, and/or wheezing |
| **SKIN** | Hives, itchy rash, and/or swelling about the face or extremities | **HEART** | "Thready" pulse, "passing out," fainting, blueness, pale |
| **THROAT** | Sense of tightness in the throat, hoarseness, and hacking cough | **GENERAL** | Panic, sudden fatigue, chills, fear of impending doom |
| **GUT** | Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea | **OTHER** | Some students may experience symptoms other than those listed above |

## EMERGENCY PLAN

**If student has any of the above symptoms or suspected exposure to above allergen(s):**

1. Inject Epinephrine ❑ 0.3 mg ❑ 0.15 mg into outer thigh muscle.
2. Call 911 – Advise Emergency Medical Services (EMS) that Epinephrine has been given for a severe allergic reaction.
3. After Epinephrine, give medication(s) listed below (*only give if safe to swallow*):
   - ❑ Antihistamine: Give _____ mg of _____ by mouth one time.
   - ❑ Bronchodilator: Inhale _____ puffs of _____ MDI.
     - ❑ Repeat every _____ minutes if symptoms persist/reoccur.
4. Repeat Epinephrine dose in _____ minutes if EMS has not arrived or symptoms persist/reoccur.

## LHCP SIGNATURE/INFORMATION

I have prescribed and the above-named student receive the above-identified medication(s) for use during school hours and school sponsored events and have instructed the student in the correct and responsible use of the medication(s) per RCW 28A.210.370 beginning with the ____ day of _____, 20_____ (not to exceed the current school year).

| LHCP Signature: | | Date: |
|---|---|---|
| LHCP Printed Name: | LHCP Phone: | LHCP Fax: |

## THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

- Due to unforeseen circumstances, I understand a dose may be delayed or missed.
- All medications must be in their original, properly labeled container with instructions matching the Medication Authorization Order.
- When notified by school personnel that medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.
- Everett Public Schools assumes no responsibility for self-carried medications.
- My signature below indicates that I have read and understand and will abide by the district medication Policy 3416.

## LEVEL OF SELF CARE

❑ **YES***, student **MAY** always self-carry and self-administer medication(s) during the school day.
❑ **YES***, student **MAY** always self-carry medication(s), but **MAY NOT** self-administer medication(s).
❑ **NO,** student **MAY NOT** self-carry medication(s), it will be stored in the health room.
***Marking "yes"** indicates that student has been thoroughly instructed in the purpose and appropriate method/frequency of use and/or safe carrying of medication(s) and that student/parent/guardian understand the responsibilities of self-carrying at school*

| ➢ Parent/Guardian Printed Name and Signature: | Date: |
|---|---|
| ➢ Student Signature: Only if authorized to self-carry | Date: |

**Internal use only:**

- Student has demonstrated the skill level necessary to use medication(s) or device as prescribed above and is authorized to self-carry medication(s) at school: ❑YES ❑ NO
- Student may self-manage medication(s): ❑YES ❑ NO

District RN Signature:_____ Date: _____

9/17; 1/19; 2/22; 4/23