MEDICATION AUTHORIZATION ORDER FOR LIFE-THREATENING ALLERGY

Student name:	DOB:
School:	Grade:

THIS PORTION TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER (LHCP)

Life-threatening severe allergy to:

For the following symptoms		**Give the following medications** (For individual symptoms, if multiple medications are selected, Epinephrine will always be given first.)		
Mouth:	Itching, tingling, or mild swelling of lips	❑ Epinephrine	❑ Antihistamine	❑ Bronchodilator
Skin:	Mild hives, itchy rash	❑ Epinephrine	❑ Antihistamine	❑ Bronchodilator
Skin:	Severe hives, swelling of face or extremities	❑ Epinephrine	❑ Antihistamine	❑ Bronchodilator
Gut:	Nausea, abdominal cramps, vomiting, diarrhea	❑ Epinephrine	❑ Antihistamine	❑ Bronchodilator
Throat:	Tightening of throat, hoarseness, hacking cough	❑ Epinephrine	❑ Antihistamine	❑ Bronchodilator
Lungs:	Short of breath, repetitive coughing, wheezing	❑ Epinephrine	❑ Antihistamine	❑ Bronchodilator
Heart:	Thready pulse, low blood pressure, fainting, pale	❑ Epinephrine	❑ Antihistamine	❑ Bronchodilator

MEDICATION/DOSES

Epinephrine Auto Injector: *Inject intramuscularly into upper outer thigh by trained staff members*
❑ Epinephrine 1:1000 USP (0.15 mg) ❑ Epinephrine 1:1000 USP (0.3 mg)
❑ A second Epinephrine dose may be given ≥ _____ minutes or more if symptoms persist or reoccur.

Antihistamine: *Give 1 time orally if student is able to swallow safely.*
❑ Benadryl/Diphenhydramine _____ mg ❑ Other: _____ _____ mg

Bronchodilator: *Inhaler dosing for severe allergic reactions only.*
❑ Albuterol Oral Inhaler _____ puffs by mouth ❑ Other: _____
Inhale _____ puffs orally once. May repeat every _____ minutes _____ times if symptoms persist

For students with Asthma: *Inhaler dosing for asthma symptoms only.*
❑*Inhale_____ puffs by mouth every ____hours as needed for asthma.*
❑*May repeat_____ puffs in _____ minutes if no symptom relief.* ❑ *Inhale____ puffs ____ minutes prior to physical activity prn.*

LEVEL OF SELF CARE

- ❑ Student **MAY** self-carry medication at all times during the school day. They have been instructed on the proper indicated administration technique, dosage, and universal precautions for this medication.
- ❑ Student **MAY NOT** self-carry medication, it will be stored in the health room.

LHCP SIGNATURE/INFORMATION

I request and authorize that the above-named student receive the above-identified medication(s) in accordance with the instructions indicated, beginning with the _____ day of _____, 20_____ (not to exceed the current school year). There exists a valid health reason, which makes administration of the medication advisable during school hours.

LHCP Signature:	**LHCP Printed Name:**	
LHCP Phone:	**LHCP Fax:**	**Date:**

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

- I request this medication to be given as ordered by the LHCP.
- My signature indicates my understanding that reasonable care will be exercised in administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the LHCP's directions.
- I understand that 911 will always be called if the Epinephrine is administered.
- I have read and understand and will abide by Board Policy 3416 & 3416P.

Parent/Guardian Signature:	**Date:**	
Home Phone #:	**Work #:**	**Mobile #:**

District RN Signature:_____ Date: _____