EVERETT PUBLIC SCHOOLS

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 Services 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.

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:		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 form.
- 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.

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

District RN Signature:_____ Date: _____

Adopted: September 2017
Revised: January 2019
Revised: February 2022