NORTHERN VALLEY REG. HIGH SCHOOL

MEDICATION AUTHORIZATION FOR SEVERE ALLERGIC REACTION SCHOOL YEAR: _____

Student's Name: _____ D.O.B. _____ Grade:_____

ALLERGY TO: _____

Asthmatic: Yes No *Higher risk for severe reaction

Symptoms:		**Give Checked Medication**
•	If a food allergen has been ingested, or if stung, but no symptoms	___Epinephrine ___ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	___Epinephrine ___ Antihistamine
• Skin	Hives, itchy rash, swelling of the face of 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

DOSAGE

Epinephrine: Inject intramuscularly (circle one) **Epinephrine Auto Inject 0.3mg** **Epinephrine Auto Inject 0.15mg**

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

NOTE: A delegate may NOT administer an antihistamine.

NOTE: Epinephrine injection may be repeated if the child's symptoms persist or get worse _____ yes _____ no
(2nd dose of Epinephrine must be provided by the parent/guardian)

HAS STUDENT HAD A DOCUMENTED EPISODE OF ANAPHYLAXIS? YES _____ NO _____

_____ Student is **not** capable of self-administration of an EpiPen or Auvi-Q.

_____ Student has been instructed in the use of an EpiPen or Auvi-Q and **may carry and self-administer**.

If EpiPen or Auvi-Q is administered, EMS (911) will be called immediately.

Health Care Provider _____ Date: _____
Signature

Please print or stamp
HCP's name: _____
Address: _____
Phone Number:_____

TO BE COMPLETED BY PARENT/GUARDIAN

I, _____, give permission for my child to receive the above medication as directed by the Health Care Provider. I understand and agree that the district shall have no liability as a result of any injury arising from administration of epinephrine and I indemnify and hold harmless the district, employees, and it's agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child.

If the school nurse is not physically present, I give permission for his/her designee to administer the medication. I understand and agree that the district, employees, and it's agents shall have no liability as a result of any injury arising from the administration of epinephrine and I indemnify and hold harmless the district, employees, and it's agents against any claims arising out of the administration of a pre-filled, single does auto-injector mechanism containing epinephrine to my child.

Parent/Guardian Signature: _____ Date: _____