

STUDENT'S NAME: _____

DATE OF BIRTH: _____ GRADE: _____ HOME ROOM: _____

To be completed by Physician

MD'S Name: (please print) _____ Phone number: _____

Please check: Allergist _____ Primary Care Physician _____ (please check)

My patient, _____ has a documented _____ or suspected _____
life-threatening allergy to _____ that may require emergency medical treatment.

Date of last allergy test: _____ Date of last significant allergic reaction: _____

Please note what happened that led to the diagnosis of this allergy: _____

Possible signs and symptoms of this student's allergic reaction that should be noted:

MOUTH: itching and swelling of the lips, tongue or mouth

THROAT: itching and/or a sense of tightness in the throat; hoarseness; hacking cough

SKIN: hives; itchy rash; swelling around the face or extremities; pallor

GASTROINTESTINAL: nausea; abdominal cramps; vomiting; diarrhea

LUNG: shortness of breath; repetitive coughing; wheezing

HEART: "thready" pulse; "passing out"; decreasing blood pressure; cardiovascular collapse

Other: _____

Other meds student is currently taking: _____

Treatment Plan

1. Administer **EpiPen 0.3 mg IM** _____ **prn in the event of** _____
EpiPen 0.15 mg IM _____ **prn in the event of** _____
2. Administer _____ for _____
3. Call 911 for transport to hospital if EpiPen is administered.
4. Permission granted for this child to self-administer the emergency medicine. Yes _____ No _____

Date: _____ Provider Signature: _____

Parent/Guardian Consent for Emergency Medication Administration

1. I have read and reviewed the Emergency Health Care Plan formulated by my child's physician. I give permission for the school nurse or her trained designee to follow the Plan. I understand that the emergency medication (s) will be sent on all field trips at the elementary and middle school level to ensure the safety of the student. High school students may carry their own medications.
2. I give permission for this information to be shared with school staff as needed for my child's safety.
3. I give permission for my child to carry and self administer the emergency medication: Yes _____ No _____
4. I have delivered an EpiPen to school. Exp Date: _____ Other med _____ Exp Date: _____

Date: _____ Parent/Guardian Signature: _____

Emergency telephone numbers: Home: _____ Work: _____ Cell: _____

School Nurse Signature: _____