PIERCE COUNTY MEDICAL SOCIETY

Health Care Provider Epinephrine Request and Treatment Plan for Anaphylaxis

School Year	School	FAX

Student Name, _____ may require treatment to prevent/treat anaphylaxis.
Student is allergic to _____.

The symptoms of anaphylaxis may include breathing difficulty, facial/throat swelling or tingling, hives, rash, itching, stomach cramps, nausea/vomiting, dizziness, or swelling away from the site of a bee sting.

The treatment plan for preventing/treating anaphylaxis at school is as follows: *(check all that apply)*

If student is exposed to allergen and/or exhibits any symptom of anaphylaxis, **Give epinephrine IMMEDIATELY**

- ❑ Epinephrine auto-injector 0.3 mg
- ❑ Epinephrine auto-injector 0.15mg
- ❑ Repeat dose of epinephrine may be given if _____

Call 911 at the time epinephrine is given and notify parent/guardian.

❑ This student also has asthma and may be at higher risk for developing anaphylaxis.

Student and parent/guardian have been instructed in use of epinephrine auto-injector. ❑ Yes ❑ No
Student may carry and self-administer the epinephrine auto-injector ordered above. ❑ Yes ❑ No

Health Care Provider's Signature | Phone | Fax

Health Care Provider's Printed Name or Stamp | Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

Parent/Guardian's Permission

I request that the school nurse, principal, or designated staff member be permitted to discuss my child's medical issues with health care providers and to administer to my child, *(name of child)* _____, or allow my child to carry and self-administer as indicated above, the medication prescribed by *(name of health care provider)* _____ for the _____ school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, **I will collect the medication from the school or understand that it will be destroyed.** I am the parent or the legal guardian of the child named.

Parent/Guardian Signature: _____ Date: _____
Phone Contacts: *Home* _____ *Cell* _____ *Work* _____ *Other* _____

THANK YOU FOR YOUR ASSISTANCE. PLEASE RETURN COMPLETED FORM TO SCHOOL NURSE.
STUDENT DEMONSTRATES SKILL LEVEL NECESSARY TO SELF-ADMINISTER MEDICATION AS ORDERED ABOVE.

School Nurse Signature: _____ Date: _____