Mounds View PUBLIC SCHOOLS

SEVERE ALLERGY MEDICATION AUTHORIZATION FORM

Student Name _____ Birth Date_____ School Year:_____

ALLERGY TO:_____

STUDENT HAS ASTHMA (*Higher risk for severe reaction) yes_____ **no_____**

MEDICATION:

Epinephrine

- **Medication name _____**
- **Dose _____ Route _____**
- **Special instructions_____**
- **CALL 911 if epinephrine administered**

Antihistamine

- **Medication name _____**
- **Dose _____ Route _____**
- **Special instructions_____**

Inhaler

- **Medication name _____**
- **Dose _____ Route _____**
- **Special instructions_____**

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Symptoms: (**Potentially life-threatening; severity of symptoms can quickly change)

(**To be determined by health care provider authorizing treatment)**	**Give Checked Medication:**			
If a food allergen has been ingested, but *no symptoms*:		Epinephrine		Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth		Epinephrine		Antihistamine
Skin: Hives, itchy rash, swelling of the face or 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, faint, pale, bluish skin		Epinephrine		Antihistamine
Other**		Epinephrine		Antihistamine
If reaction is progressing (several of the above areas affected)		Epinephrine		Antihistamine

_____ Student is knowledgeable about use of medication and can safely carry to self-administer with staff support following evaluation by the licensed school nurse.

_____ _____ _____
Licensed Health Care Provider (name) (signature) Date

_____ _____ _____
Clinic Phone # Fax #

I authorize the Licensed School Nurse to consult with my child's Licensed Health Care Provider regarding my child's allergy/asthma conditions to clarify medication orders/treatment plans to provide safe care.

_____ _____ _____
Parent/guardian name Parent/guardian signature Date