Student_____ Birthdate_____ School_____ Year_____

Physician to complete

Identified life-threatening allergen(s) are:_____

Student has demonstrated use to LHCP and may : Yes No

Physicians order for epinephrine auto-injector 0.15mg 0.3mg

Repeat dose in 10 minutes if symptoms persist and EMS has not arrived Yes No

Student has asthma (high risk for severe reaction) Yes No Inhaler_____ Dose: _____ Puffs

1. Administer auto-injector if student is unable or not authorized to self-administer **for suspected or actual exposure to above noted life-threatening allergen(s)**
2. Call 911
3. If other medication is prescribed administer as ordered.

If epinephrine auto-injector is not immediately available, call 911.

Symptoms of anaphylaxis may include:	
Gastrointestinal:	*Nausea, stomachache, abdominal cramps, vomiting, diarrhea*
Heart:	*Passing out, fainting, pale or bluish skin color*
Lung:	*Shortness of breath, repetitive coughing, wheezing*
Mouth:	*Itching, tingling, or swelling of the lips, tongue or mouth*
Skin:	*Hives, itchy rash, swelling about the face or extremities*
Throat:	*Sense of tightness in the throat, hoarseness, hacking cough*
General:	*Panic, sudden fatigue, chills, fear*
Other:	*Some students may experience symptoms other than those listed above*

Parent/guardian to complete:

I authorize my child to self-administer and carry their epinephrine auto-injector: **Yes** **No**

I request my child sit in a specified allergy aware area during lunch time: **Yes** **No**

Medication Authorization: Health Care Provider and Parent/Legal Guardian signatures required: I request and authorize that the above-named student be administered the above identified medication in accordance with the instructions indicated above for a potentially life-threatening condition. I understand that **trained unlicensed school personnel** may be delegated to administer the emergency epinephrine auto-injector. By signing this I consent to exchange of information regarding this medication authorization between the school and the health care provider. I have read and understand the information on page 2 of this form.

Health Care Provider Signature_____ Date_____

Health Care Provider Name_____ Phone Number_____

Parent/Guardian Signature_____ Date_____

The parent/guardian must provide new order