

# OLD TAPPAN PUBLIC SCHOOL DISTRICT

## MEDICATION AUTHORIZATION FOR SEVERE ALLERGIC REACTION

For school year \_\_\_\_\_

Student's name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade \_\_\_\_\_

ALLERGY TO \_\_\_\_\_

Does student have asthma? Yes No \*Higher risk for severe reaction

### Symptoms:

\*If a food allergen has been ingested, or stung, but no symptoms  
\*Mouth Itching, tingling, or swelling of lips, tongue, mouth  
\*Skin Hives, itchy rash, swelling of face or extremities  
\*Gut Nausea, abdominal cramps, vomiting, diarrhea  
\*Throat Tightening of throat, hoarseness, hacking cough  
\*Lung Shortness of breath, repetitive coughing, wheezing  
\*Heart Thready pulse, low blood pressure, fainting, pale, blueness  
\*Other \_\_\_\_\_

### Give checked medication

\_\_\_\_\_ Epinephrine \_\_\_\_\_ Antihistamine  
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### DOSAGE

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

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  
(2<sup>nd</sup> 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.

The prescriber certifies that the student is physically fit to attend school and is free of contagious disease.

Prescriber's signature \_\_\_\_\_ Print name \_\_\_\_\_ Date \_\_\_\_\_

Prescriber's address \_\_\_\_\_ Phone \_\_\_\_\_

### 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 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 dose auto-injector mechanism containing epinephrine to my child.

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

SCHOOL PRINCIPAL APPROVAL \_\_\_\_\_ Date \_\_\_\_\_