Medication Permission Form for Life-Threatening Allergies

ALLERGY TO: ____

Student's
Name: ______________________________ D.O.B. ________ Teacher ________________

Asthmatic: _____**Yes*** _____ **No** ***High risk for severe reaction**

THIS CHILD'S SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
·MOUTH*	itching & swelling of the lips, tongue, or mouth
·THROAT	itching and/or a sense of tightness in the throat, hoarseness, and hacking couch
·SKIN	hives, itchy rash, and/or swelling about the face or extremities
·GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
·LUNG*	shortness of breath, repetitive coughing, and/or wheezing
·HEART*	"thread" pulse, "passing-out"

The severity of symptoms can quickly change. * All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

If only symptom(s) are: ______________________________, give ______________________
medications/dose/route

____

Then call:
1. Mother ________________________, Father ______________________, or emergency contacts.

2. Dr. ______________________________ at ______________________________

This child may/ may not carry this medication. Name where; school, sports events, out of school activities.
If condition does not improve within 10 OR ___minutes follow the steps for "Action for Major reaction" below:

ACTION FOR MAJOR REACTION
If ingestion is suspected and/or symptom(s) are: ______________________________ _____ give

____ **IMMEDIATELY!**
Medications/dose/route
Then call:
1. 911 (ask for advanced life support)

2. Mother ________________________, Father ______________________, or emergency contacts.

3. Dr. ____ at ______________________________
This child may/may not carry this medication. Name where; school, sports events, out of school address activities.

DO NOT HESITATE TO CALL 911!

______________________	__________	______________________	__________
Physician's Signature	**Date**	**Parent's signature**	**Date**

EMERGENCY CONTACTS		TRAINED STAFF MEMBERS	
1.		1.	Room
Relation:	Phone:		
2.		2.	Room
Relation:	Phone:		
3.		3.	Room
Relation:	Phone:		

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray safety cap

2. Place black tip on outer thigh (always apply to thigh)

3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.

____________________ (Student's Name) has severe allergies to ____________________. This allergy may cause ____________________
in my child. I have provided to the school the physician's medication permission and instructions. I want these instructions carried out. I have instructed my child of about his/her allergy, how to avoid exposure to the allergen, care to take if exposed occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication.

I hereby request that treatment the medication specified above to be given to the above named student, and that someone may give the medication other than a medically trained person. I know 911 will be called with the use of ephinephine.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein. I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, an employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature ____________________ Date____________________This "Emergency
This "Allergy Medication Permission Form" may be given to appropriate Teachers, Substitute teachers and Staff.

Individualized Health Care Plan for Life-Threatening Allergies Including Food Allergies

To be completed by the student or parent if the child is too young:

Students Name______________________________ Grade__________________

I have allergy/s to ______________________________. I know I need to avoid

____.

The reaction/s I have are: ____

____

____

I know my care is ____

____

____

The medication I need is ____

How is the medication given? ____

The medication located (where) ______________________________. The back up location for my medication is ______________________________.

I do have/ do not have permission to carry my medication. __________________

I will carry the medication (where) ______________________________. The back up location for my medication is ______________________________.

I will tell the responsible adult immediately if I have came in contact will the allergen or I am having a reaction.

List any requires needed for food allergies.

Student signature______________________________ Date__________________

To be completed by the Parent

____________________ (Student's Name) has severe allergies to __________________. This allergy may cause ____ in my child. I have provided to the school the physician's medication permission and instructions. I want these instructions carried out. I have instructed my child of about his/her allergy, how to avoid exposure to the allergen, care to take if exposed occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication.

I hereby request that treatment the medication specified above to be given to the above named student, and that someone may give the medication other than a medically trained person. I know 911 will be called with the use of ephinephine.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein. I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, an employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature______________________________________Date__________________

To be completed by the school

____ Instruction has been given on the medication order and the parent's instruction of care.

____ The students' responsible adults are instructed in the allergy, symptoms, and avoidance, care, and treatment.

____ Epinephrine auto injected device locations are known.

____ If the Epipen is used 911 with advance life support will be called.

Principal________________________School Nurse or Health Consultant______________

Teacher______________________________ PE ______________________ (If appropriate)

Extended Day Coordinator ______________

Coach ____Date______________

Physician ________________________ Date ____________