School District of Kettle Moraine

# Medication Administration for Allergic Reaction

School: Phone Fax

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|---|---|---|
| Student's Name: | | Date: |
| School Attending: | Grade: | Bus Student: Yes No Route_____ |
| Health Condition: Allergy – | | |

| Symptoms: | | Give Checked Medication**: (**To be determined by physician authorizing treatment) | |
|---|---|---|---|
| • 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, low blood pressure, fainting, pale, blue | □Epinephrine | □Antihistamine |
| • Other†: | _____ | □Epinephrine | □Antihistamine |
| • If reaction is progressing (several of the above areas affected), give: | | □Epinephrine | □Antihistamine |

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr.

Antihistamine: give: medication/dose/route _____

Other: give: medication/dose/route _____

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

Possible Side Effects: _____

Direct contact shall be made with the physician should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state): _____

EMERGENCY CALLS

1. Call 911. State that student is having an allergic reaction and what medication has been given.

2. Dr. _____ at _____

3. Emergency contact: Name/Number/Relationship to student

_____/_____/_____

Every effort will be made to contact the parent / guardian. If parent cannot be reached follow emergency plan and administer medication and call 911

Medication Consent:: As parent of the above named student, I give permission to designated trained school staff to administer the drug products authorized above by my physician, according to the written instructions as shown on this form. I authorize the school nurse to contact the physician directly for clarification of this medical order or to report any adverse reactions or side effects. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.
I understand that additional information may be required for out of state / country or overnight field trips.

Authorization is hereby granted to release this information to appropriate school personnel and responding emergency medical staff.

Parent's Signature: Date:

Physician Order: The above medication is to be administered as indicated for allergic reaction. I agree to accept communication from school staff and understand that medication may be administered by non medical trained staff.

Physician's Signature: Date: