School District of Kettle Moraine

Medication Administration for Allergic Reaction

Student Photo

School: **Phone** **Fax**

Student's Name:		**Date:**
School Attending:	**Grade:**	**Bus Student:** Yes No Route____

Health Condition: A l l e r g y

Date of Last Reaction:

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

DOSAGE

Epinephrine: Inject intramuscularly – CALL 911 IF ADMINISTERED

- ☐ **Epinephrine Auto Injector 0.15mg**
- ☐ **Epinephrine Auto Injector 0.30mg**

Antihistamine: give: Medication : _____ Dose: _____ Route: _____ Frequency: _____

Other: give: Medication: _____ Dose: _____ Route: _____ Frequency: _____

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

This student has been instructed on his/her symptoms and when and how to administer Epinephrine Auto Injector

- ☐ **May Self Carry**
- ☐ **May Self Administer**

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:**

Parent 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:

School Nurse Signature: _____ Date: _____