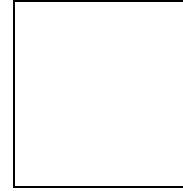




**School District of Kettle Moraine**  
**Medication Administration for Allergic Reaction**



Student Photo

School: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

|                                |                     |  |  |
|--------------------------------|---------------------|--|--|
| <b>Student's Name:</b> _____   |                     | <b>Date:</b> _____                     |  |
| <b>School Attending:</b> _____ | <b>Grade:</b> _____ | <b>Bus Student:</b> Yes No Route _____ |  |

**Health Condition: Allergy**

Date of Last Reaction: \_\_\_\_\_

| <b>Symptoms:</b>  | <b>Give Checked Medication***</b><br><small>***(To be determined by physician authorizing treatment)</small> |  |
|---|--|--|
| If a food allergen has been ingested, but no symptoms:                  | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| Mouth: Itching, Tingling, or swelling of lips, tongue, mouth            | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| Skin: Hives, itchy rash, swelling of the face or extremities            | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| Gut: Nausea, abdominal cramps, vomiting, diarrhea                       | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| Throat: Tightening of throat, hoarseness, hacking cough                 | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| Lung: Shortness of breath, repetitive coughing, wheezing                | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| Heart: Thready pulse, low blood pressure, fainting, pale, blue          | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| Other: _____  | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> Antihistamine |
| If reaction is progressing (several of the above areas affected), give: | <input type="checkbox"/> Epinephrine   | <input type="checkbox"/> 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: \_\_\_\_\_