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 cough
·**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 blue safety cap

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

3. Swing and firmly push the orange tip for 10 seconds against the mid outer thigh, The EpiPen® unit should then be removed and discarded.

_____ (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 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 treatment of 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 epinephrine.

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_____
"Allergy Medication Permission Form" may be given to appropriate Teachers, Substitute Teachers, and Staff.

Requirements for Developing a Individualized Health Care Plan for Life-Threatening Allergies

An allergy is a systemic or local reaction to "triggers." The body can respond to triggers with mild symptoms to life-threatening allergic anaphylaxis.

"Requirements for Developing an Individualized Health Care Plans for Life-Threatening Allergies" will cover the responsibility of the parents, school, and student. Follow the steps out lined in "Serious Chronic Illness" for help in developing a health care plan. The "Emergency Allergy Medication Permission Form" and the "Individualized Health Care Plan for Life Threatening Allergies including Food Allergies" can be used.

Parents

- Notify the school of all allergies a student has.
- Educate the student about the allergies.
- Educate the school on the allergen and avoidance of the allergen.
- Provide a written and signed statement form by the physician that includes requirements from the "Medication at School "section and the following:
  a. the student's allergy, signs and symptoms, and instruction for care,
  b. the times at which or circumstances under which the medicine may be administered;
  c. when to call EMS.
- Provide a written statement releasing the school, the Archdiocese and diocesan employees and agents from liability for an injury arising from medication use. Also identifying the school, the school district, its employees and agents from any claim arising from the student's medication use.
- Provide the medication with proper medication label. Replace the medication after use or upon expiring.

School

- The school will take all steps necessary to help a student with allergies avoid the allergen.
- For a student with severe allergies, the parent, student, principal, school nurse or health consultant, teacher, and if appropriate coaches, the before and after program coordinator, and others will develop and sign an individualized health care plan
- All teachers, the principal, nurse or health consultant, and if appropriate coaches and the before and after program workers need to know the student who has serious allergic reactions, the signs and symptoms of a reaction, instruction of care, and proper treatment.
- All teachers, the principal, nurse or health consultant, and if appropriate, coaches and the before and after program workers need to know the students who are on epinephrine treatment. They need to know the specific allergy, the warning signs, where the medication is, and emergency treatment. Any time an Epipen is used 911 will be called and Advanced Life Support will be asked for.
- All teachers, the principal, nurse or health consultant, and if appropriate, coaches and the before and after program workers need to know the location of the epinephrine (Epipen) that is with the student and the location of the back up.

Student

- Every student with an allergy needs to know his/her allergy, how to avoid the allergen, the reaction they have, care they need, restriction, and treatment.
- The student, if ordered, can carry his/her own epinephrine auto-injector device that is labeled appropriately including the expiration date and stating in writing where the student will carry the Epipen. The student will know the back-up location and the location will be stated in writing. The student is to notify an adult immediately if he/she has come in contact with allergen.

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 come in contact will the allergen or I am having a reaction.
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 exposure occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request treatment of 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 epinephrine. 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) Before & After Program Coordinator _____

Coach _____Date_____

Physician _____ Date _____