

AUBURN UNION SCHOOL DISTRICT
Parent Consent and Healthcare Provider Authorization
For Management of Anaphylaxis at School
“Severe Allergic Reaction”
Individualized School Healthcare Plan (ISHP)

Date _____

Student Name	Birth Date	Grade
Address	Home Phone	Work Phone

PARENT CONSENT

I (we), the undersigned and parent(s)/guardian(s) of the above named pupil, request the following for the Management of Severe Anaphylaxis/Allergic reaction in school be administered to our (my) child in accordance with California Education Code §49423.5. I will:

1. Provide all medications, supplies, and equipment
2. Notify the School Nurse if there is a change in the pupil’s health status or attending physician
3. Notify the School Nurse immediately, and provide new consent, for any changes in the doctor’s orders
4. **I acknowledge that if my student carries and administers his/her own medication, it must be on his/her person in order to attend a field trip**

I authorize the School Nurse to communicate with the Authorized Health Care Provider when necessary in regards to this specific medication and medical condition. I will be provided with a copy of my child’s completed ISHP.

Parent/Guardian Signature _____

Date _____

Health Care Provider Authorization
For the Administration of Medication by School Personnel

1. Allergic Reaction to: _____

Asthmatic Yes No
(Asthmatics are at high risk for severe reaction)

Symptoms	Give Checked Medication** **To be determined by physician authorizing treatment	
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 - Weak or thready pulse, low blood pressure, fainting, pale, blueness	<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

2. Medication #1: _____

3. Dose: _____

4. Method of Administration: _____

5. Medication#2: _____

6. Dose: _____

7. Method of administration: _____

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

- Call 911 at the beginning of the crisis**
- Administer the medication as ordered**
- Ensure adequate airway**
- Perform CPR if needed**
- Call School Nurse**
- Call Parent**
- Assist paramedics as needed**

**AUTHORIZED CONSENT FOR MANAGEMENT OF SEVERE
ANAPHYLAXIS/ALLERGIC REACTION AT SCHOOL**

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with California state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the School Nurse. This authorization is for a maximum of one (1) year. If changes are indicated, I will provide new written authorization. (May be faxed)

- **I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and administer the medication by him/her.**
- **It is my professional opinion that _____ should NOT carry or administer his/her medication by him/her.**

Physician's Signature: _____

Date: _____

Address: _____

Phone: _____

Principal's Signature: _____

Date: _____

Nurse's Signature: _____

Date: _____

Created 4/21/2010 bde