School Nursing
Life-Threatening Allergy IHP

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN

I, the parent/guardian of _____dob_____
request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours. And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.
5. I give permission for my child to self administer rescue medication if approved by physician

ALLERGIES: _____

Asthma: ( ) yes – higher risk for severe reaction ( ) no

( ) If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten
( ) If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Signs and Symptoms of an Allergic Reaction:

MOUTH:	itching, swelling of lips and/or tongue
THROAT*:	itching, tightness/closure, hoarseness, trouble breathing/swallowing
SKIN:	itching, hives, redness, swelling
GUT:	vomiting, diarrhea, cramps
LUNG*:	Shortness of breath, cough, wheeze
HEART*:	weak pulse, dizziness, passing out, pale, faint

The Severity of Symptoms Can Change Quickly and Progress to a Life-Threatening Situation. Do not depend on antihistamines to treat a severe reaction. Use Epinephrine.

1. MEDICATIONS: ( ) Epinephrine 0.15mg ( ) Epinephrine 0.3mg
( ) Antihistamine- name/dose_____
( ) If checked, OK for student to carry/self-administer.

2. Call 911

3. Parent/guardian/emergency contact:_____

Comments:_____

Signature of Parent/Guardian: _____ Relationship: _____ Date: _____

PLEASE REVIEW PARENT PROVIDED INFORMATION, SIGN AND RETURN

_____ _____
Physician's name printed Physician's signature

Physicians's address: _____

Phone: _____ Fax:_____Date: _____

- ☐ Fennville Public Schools
- ☐ Hamilton Public Schools
- ☐ Holland Christian Schools
- ☐ Holland Public Schools
- ☐ West Ottawa Public Schools

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.