Parent Consent and Healthcare Provider Authorization
For Management of Anaphylaxis at School "Severe Allergic Reaction"
Individualized School Healthcare Plan (ISHP)

Student Name	Birthdate	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 exposed to a known allergen, but no symptoms	□ Antihistamine	□ Epinephrine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth	□ Antihistamine	□ Epinephrine
Skin – Hives, itchy rash, swelling of the face or extremities	□ Antihistamine	□ Epinephrine
Gut – Nausea, abdominal cramps, vomiting, diarrhea	□ Antihistamine	□ Epinephrine
† **Throat** - Tightening of throat, hoarseness, hacking cough	□ Antihistamine	□ Epinephrine
† **Lung** - Shortness of breath, repetitive coughing, wheezing	□ Antihistamine	□ Epinephrine
† **Heart** - Weak or thready pulse, low blood pressure, fainting, pale, blueness	□ Antihistamine	□ Epinephrine
† **Other**_____	□ Antihistamine	□ Epinephrine
If reaction is progressing (several of the above areas affected), give	□ Antihistamine	□ Epinephrine

2. **Antihistamine**: ☐ Diphenhydramine ☐ Other _____

3. Dose: _____

4. Method of Administration: _____

5. **Epinephrine**: ☐ Epinephrine Auto Injector ☐ Other _____

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 Use of his/her medications. It is my professional opinion that he/she should be allowed to carry and administer the medication by himself/herself.

☐ It is my professional opinion that _____ should NOT carry or self - administer his/her medication.

☐ Student should be supervised in administering medication, but MAY SELF CARRY medication.

Physician's Signature: _____ **Date:** _____

Address: _____ Phone: _____

School Nurse's Signature: _____ Date: _____

02/16 jh/blm