BERRYESSA UNION SCHOOL DISTRICT ALLERGY HEALTH PLAN SCHOOL_____ GR: ___ YR: _____

PHYSICIAN AUTHORIZATION (HCP complete): **Form valid ONLY for CURRENT school year, including summer school.**

Student: _____ DOB:_____ **Child has had anaphylaxis** ☐**Yes** ☐**No**

Specific Allergies: _____ **Asthma [ ]Yes-**higher chance severe reaction) **[ ]NO**

Child may Carry AND Self-Administer: Epinephrine Yes / No Bronchodilator: Yes / No Antihistamine: Yes / No

If **YES**: _____***MD INITIAL*** I authorize this student must carry this emergency/otherwise necessary medication on his/her person. The student has been instructed in the proper administration of this medication, understands the appropriate dosage and possible side effects & is **competent to safely self-administer this medication** per the above written statement.

Give checked medicine(s) ***(Determined by authorizing PHYSICIAN):following known or suspected allergen contact or ingestion:***

A. No symptoms	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
B. Mouth: Itching, tingling	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
C. Mouth: Swelling of lips, tongue, mouth	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
D. Skin: Hives, itchy rash	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
E. Skin: Swelling of face or extremities	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
F. Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
G. Throat: Tightening, hoarseness, hacking cough	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
H. Lungs: Shortness of breath, repetitive cough, wheezing	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine
I. Heart: Fainting, pale or blue discolored skin	☐ Epinephrine	☐ Bronchodilator	☐ Antihistamine

Epinephrine Injection Dose (specify): ☐ 0.15 mg ☐ 0.3 mg ☐ Auvi-Q 9-1-1 WILL BE CALLED

Bronchodilator(name):_____**Dose (specify):** _____**mg ☐ 2 puffs inhaled ☐ 4 puffs inhaled**
Bronchodilator( )Daily Time_____**OR**( )PRN (as needed). If PRN (as needed), **Frequency**_____
Additional Instructions(indicated for symptoms)**:** _____**Side Effects**_____

Antihistamine(name):_____**Dose (specify):**_____**mg/ml, give** _____**ml orally by mouth**
( )Daily Time_____**OR**( )PRN (as needed). If PRN (as needed), **Frequency**_____
Additional Instructions(indicated for symptoms)**:** _____**Side Effects**_____

PARENT/GUARDIAN CONSENT:

I hereby request that the school assist with the administration of the above-mentioned medication/s to my student, in accordance with California Education Code 49423 & 49480. I give my consent for the school nurse or other designated school personnel to contact the health care provider to exchange information regarding the above orders.. I will provide medication with original label, and will dispose of medication/s.

_____

Parent/Guardian Signature ***Date***

PARENT EMERGENCY PHONE:_____

HEALTH CARE PROVIDER'S STAMP

I am aware that this medication may be given by designated unlicensed personnel.

Dr. Clinic/Stamp

_____

Provider's Signature ***Date***

SCHOOL STAFF ALLERGY PLAN*: *GIVE ALLERGY MEDICATION(S) PER PHYSICIAN AUTHORIZATION-ABOVE:

MILD SYMPTOMS: Give antihistamine. Monitor, Observe, notify parents, alert office staff. If symptoms become severe, use epi-pen.

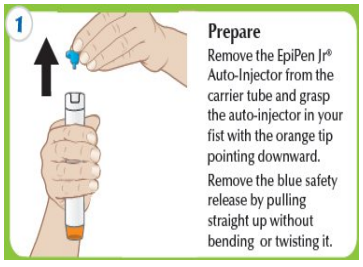
SEVERE SYMPTOMS: GIVE EPI-PEN, Call 9-1-1 & Parent/Guardian. Tell Paramedic Epi-Pen was given, note time and transport location..

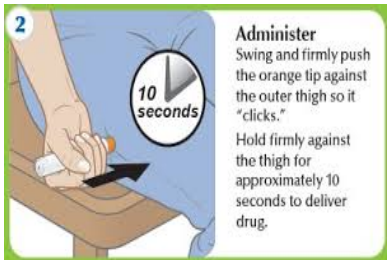
Give additional medications if ordered by MD. Student to lay flat, elevate legs; Turn on side-if vomits. **If breathing stops at any time, start CPR.**

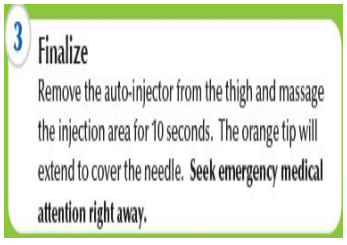
***ANAPHYLAXIS: IS A POTENTIALLY LIFE-THREATENING, SEVERE ALLERGIC REACTION. IF IN DOUBT, GIVE EPI-PEN.**

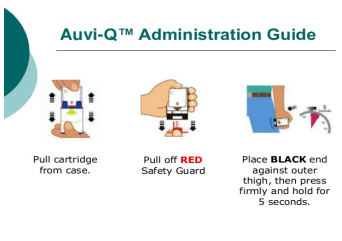
On Field Trips: Cell phone, medication(s), this form with emergency contacts info-must accompany trained staff/student.

EPINEPHRINE (EPI-PEN) TRAINING VIDEO**: https://www.youtube.com/watch?v=EN83hen4D-Y**









STAFF SIGNATURE DATE STAFF SIGNATURE DATE STAFF SIGNATURE DATE