BERRYESSA UNION SCHOOL DISTRICT ALLERGY					GR:	
PHYSICIAN AUTHORIZATION (HCP complete): For						
Student:	_DOB:	(	Child has had	d anaphy	'laxis ⊔	Yes
Specific Allergies:			thma [ ]Yes-hi	•		, -
Child may Carry AND Self-Administer: Epinephrine						
If <b>YES</b> : <i>MD INITIAL</i> . I authorize this student <u>must</u> carry this been instructed in the proper administration of this medication, und						
safely self-administer this medication per the above written st	• • • • • • • • • • • • • • • • • • • •	upriate uosag	e anu possible s	מוטה פוופפנט	α 13 <u>comp</u>	<u>JIGHL LU</u>
Give checked medicine(s) (Determined by authorizing PH		na known d	or suspected a	allergen c	ontact or	inaestic
A. No symptoms		inephrine	☐ Broncho	_	☐ Antihis	_
B. Mouth: Itching, tingling		inephrine	☐ Broncho		☐ Antihis	
C. Mouth: Swelling of lips, tongue, mouth		inephrine	☐ Broncho		☐ Antihis	
D. Skin: Hives, itchy rash		inephrine	☐ Broncho		☐ Antihis	
E. Skin: Swelling of face or extremities		inephrine	☐ Broncho		☐ Antihis	
F. Gut: Nausea, abdominal cramps, vomiting, diarrh		inephrine	☐ Broncho		☐ Antihis	
G. Throat: Tightening, hoarseness, hacking cough		inephrine	☐ Broncho		☐ Antihis	
H. Lungs: Shortness of breath, repetitive cough, who		inephrine	☐ Broncho	dilator	☐ Antihis	stamine
I. Heart: Fainting, pale or blue discolored skin		inephrine			☐ Antihis	stamine
Epinephrine Injection Dose (specify):   0.15 mg				1 WILL	<b>BE CAL</b>	LED
Bronchodilator(name):OR(_)PRN (as Additional Instructions(indicated for symptoms):	•		0 "		· · ·	
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