Medication Permission Form for Life-Threatening Allergies

ALLERGY TO: ____

Student's
Name: ________________________________ D.O.B. ________ Teacher __________________________

Asthmatic: _____**Yes*** _____ **No** ***High risk for severe reaction**

THIS CHILD'S SIGNS OF AN ALLERGIC REACTION

Systems	**Symptoms**
·**MOUTH***	itching & swelling of the lips, tongue, or mouth
·**THROAT**	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
·**SKIN**	hives, itchy rash, and/or swelling about the face or extremities
·**GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
·**LUNG***	shortness of breath, repetitive coughing, and/or wheezing
·**HEART***	"thread" pulse, "passing-out"

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

ACTION FOR MINOR REACTION

If only symptom(s) are: ____________________________________, give ________________________________
medications/dose/route
____

Then call:
1. Mother _________________________________, Father ___________________________, or emergency contacts.

2. Dr. ____ at ____

This child may/ may not carry this medication. Name where; school, sports events, out of school activities.
If condition does not improve within 10 OR ___minutes follow the steps for "Action for Major Reaction" below:

ACTION FOR MAJOR REACTION
If ingestion is suspected and/or symptom(s) are: ____ give

____ **IMMEDIATELY!**
Medications/dose/route
Then call:
1**. 911 (ask for advanced life support)**

2. Mother ___________________________, Father _______________________, or emergency contacts.

3. Dr. ____ at ___________________________________
This child may/may not carry this medication. Name where; school, sports events, out of school address activities.

DO NOT HESITATE TO CALL 911!

_________________________ ____________ ______________________________ __________
Physician's Signature **Date** **Parent's signature** **Date**

EMERGENCY CONTACTS		TRAINED STAFF MEMBERS	
1.		1. ______	Room ______
Relation: ______	Phone: ______		
2.		2. ______	Room ______
Relation:	Phone: ______		
3. ______	______	3. ______	Room ______
Relation: ______	Phone: ______		

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off blue safety cap

2. Place orange tip on outer thigh (always apply to thigh)

3. Swing and firmly push the orange tip for 10 seconds against the mid outer thigh.

4. Remove EpiPen® unit and massage the area for 10 seconds. The EpiPen® should be discarded.

________________________________ (Student's Name) has severe allergies to ________________________. This allergy may cause

____
in my child. I have provided to the school the physician's medication permission and instructions. I want these instructions carried out. I have instructed my child about his/her allergy, how to avoid exposure to the allergen, care to take if exposed occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication.

I hereby request treatment of the medication specified above to be given to the above named student, and that someone may give the medication other than a medically trained person. I know 911 will be called with the use of epinephrine.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein. I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, an employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature _______________________________________ Date_______________________
"Allergy Medication Permission Form" may be given to appropriate Teachers, Substitute Teachers, and Staff.