



**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	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Skin – Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
Gut – Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
† Throat - Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
† Lung - Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
† Heart - Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
† Other _____	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Epinephrine
If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> 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: _____