TWIN RIVERS SCHOOL DISTRICT

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

2. **Medication #1**:______________________________

3. Dose:______________________________

4. Method of Administration:______________________________

5. **Medication#2**:____

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 way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and administer the medication by him/her.**

- **It is my professional opinion that _______________________ should NOT carry or administer his/her medication by him/her.**

Physician's Signature:_______________________ **Date:**__________

Address:_______________________ Phone:__________

Nurse's Signature:_______________________ Date:__________