AUTHORIZATION FOR ADMINISTERING MEDICAL TREATMENT TO CHILDREN WITH SEVERE ALLERGIES

Date _____

Dear Doctor _____

Your patient, _____ is enrolled/enrolling in our School and we have been requested to provide certain medical treatment for the prevention of anaphylaxis in the event the child comes into contact with certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at our school so we may assist with the allergy care and needs of our student and your patient. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, that will become a part of this record and will be kept with this form in the child's file at _____ School.

Child's name: _____
Child's date of birth: _____

PART I (to be completed by physician)

ALLERGENS:

Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction, (i.e. anaphylactic shock) in the child.

_____ Bee sting

_____ Other insect bite(s): (Identify) _____

_____ Animal fur: (Identify) _____

_____ Food Allergy: (Identify all foods that must be avoided) _____

_____

_____ Other: (Identify) _____

_____

SYMPTOMS:

Please provide a complete list of all symptoms indicating that the child has come into contact with an allergen and that he/she requires emergency treatment.

_____ Shortness of breath or difficulty in breathing

_____ Swelling of the face or lips

_____ Hives

_____ Vomiting

_____ Diarrhea

_____ Other: (Explain) _____

_____ Do not administer medication in the absence of known exposure to allergen. (Explain) _____

PROCEDURES:

Please indicate all steps necessary and the order in which they should be taken.

_____ Give Benadryl Elixir orally (dosage _____)

_____ Administer EpiPen, Jr. or _____

_____ Call the area's emergency medical personnel (e.g. "911")

_____ Call parent(s)/guardian(s), and child's physician

_____ Other (Explain) _____

RECREATIONAL ACTIVITIES:

1. The child may participate in recreational activities. ( )Yes ( ) No

2. Activity restrictions: ( ) None ( ) Some restrictions
   (Explain): _____

_____

CHILD'S PHYSICIAN:

Name: _____

Address: _____

Telephone #: _____

Emergency contact #: _____

Signature: _____ Date: _____

PART II (to be completed by parents)

Parent(s)/Guardian(s):

Name: _____

Address: _____

Telephone #: _____

Emergency Contact #: _____