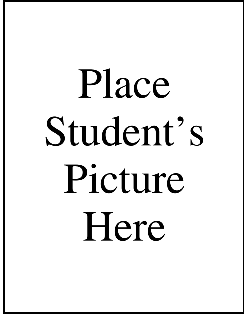
Valid for School Year
__________ to __________
Epipen ________________
Expiration date
Antihistamine __________
Expiration date



POWAY UNIFIED SCHOOL DISTRICT
13626 Twin Peaks Road, Poway, CA 92064-3034

SUGGESTED PROCEDURE IN CARING FOR STUDENTS WITH

POTENTIAL ANAPHYLACTIC REACTION

STUDENT NAME_______________________________________ **BIRTHDATE**____________________________

SCHOOL____ **GRADE**________________________________

ALLERGY____

Physician:
Please provide the following specific instructions to assist our Health Technician (or school staff) in providing emergency care as needed during school hours. Although our credentialed school nurses are not at the school, indirect supervision will be provided from the central office. 911 will be called when epinephrine is administered.

TREATMENT:

Symptoms:	**Give Checked Medication**	
• If an exposure incident has occurred, 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* - Thready pulses, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• Other:*	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. *Potentially life threatening.

Dosage:

Epinephrine: inject intramuscularly ☐ Epipen ☐ Epipen Jr.

Antihistamine: give____
Medication/dose/route

Other: give____
Medication/dose/route

PHYSICIAN'S SIGNATURE_________________________________ **Date** __________________________

Phone_____________________ **Fax**_____________________**CA Med. License#**_____________________

I have read and accept conditions set forth by Poway Unified School District for treatment of Anaphylaxis (see page 2).

PARENT SIGNATURE: _______________________**Phone**_______________**Date:**___________________

POWAY UNIFIED SCHOOL DISTRICT
13626 Twin Peaks Road, Poway, California 92064-3098

PARENT AUTHORIZATION FOR SPECIALIZED PHYSICAL HEALTH CARE SERVICE

I understand that only personnel meeting the requirements of California Education and Administration Codes will be performing the above mentioned health care service and will be using only the standardized procedure approved by our physician.

I will provide the medicine(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician *and* a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement.

I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

To facilitate the foregoing, I hereby grant permission for the exchange between our physician and the Poway Unified School District of that confidential medical information contained in my child's records necessary to accomplish this service.

I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change in or cancellation of the procedure.