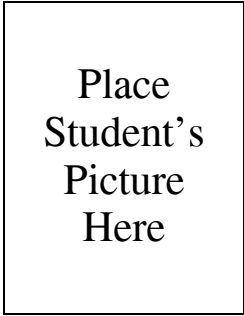


Valid for School Year
 _____ to _____
 Epipen _____
 Expiration date
 Antihistamine _____
 Expiration date

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:

- If an exposure incident has occurred, but no symptoms
- Mouth - Itching, tingling
- Mouth – Swelling of lips, tongue, mouth
- Skin - Hives, itchy rash
- Skin – Swelling of the face or extremities
- Gut - Nausea, abdominal cramps, vomiting, diarrhea
- Throat* - Tightening of throat, hoarseness, hacking cough
- Lung* - Shortness of breath, repetitive coughing, wheezing
- Heart* - Thready pulses, low blood pressure, fainting, pale, blueness
- Other:*

Give Checked Medication

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> 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

Additional Comments: _____

This portion to be completed by a physician licensed in the State of California.

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.