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 #: ___________________________________