SS-501

EDMONDS SCHOOL DISTRICT
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR LIFE-THREATENING ALLERGIC REACTION AT SCHOOL

Student's Name: _____ DOB: _____ Grade: _____ School: _____ _____

HEALTH CARE PROVIDER (HCP) ORDERS – Emergency Medications

Anaphylaxis (Severe allergic reaction) is an excessive reaction to a foreign substance that has been eaten, injected, inhaled, or absorbed

USUAL SIGNS of an allergic reaction:

MOUTH – Itching, tingling, or swelling of lips, tongue, or mouth

THROAT- Sense of throat tightness, hoarseness & hacking cough

LUNG – Shortness of breath, repetitive coughing, and/or wheezing

General – Panic, sudden fatigue, chills, fear of impending doom

SKIN – Hives, itchy rash, and/or swelling about the face or extremities

GUT – Nausea, stomachache/abdominal cramps, vomiting, or diarrhea

Heart – "Thready" pulse, "passing out," fainting, blueness, paleness

Other: _____

Medication order start date: _____ End date (not to exceed current school year): _____☐ Last day of school ☐

Life-Threatening ALLERGY to: _____ Other Allergies: _____

Date of last reaction, if known:_____ Asthmatic? (High risk for life-threatening reaction) Yes ☐ No ☐

If a student has signs listed above, or you suspect exposure (is stung by an insect, eats food he/she is allergic to, or contacts allergen):

1. GIVE ☐ EpiPen ® (0.3 mg.) ☐ EpiPen Jr.® (0.15 mg.) Injection to OuterThigh Muscle
2. CALL 911

☐ Repeat Epi-pen® in 10 to 15 minutes if EMS has not arrived.

☐ After EpiPen®, give medication IF listed below, conscious & able to swallow:

☐ _____(dose) of _____(Benadryl® or antihistamine) by_____ (route)

If history of asthma and wheezing, shortness of breath, or complaints of chest tightness with allergic reaction,

☐ After EpiPen®, and any med listed above, give rescue inhaler _____# puffs of _____

Important: Asthma inhalers &/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis

If given an** EpiPen® **student must be monitored by medical personnel and a parent, so may NOT remain at school.

SIDE EFFECTS of medication(s): EpiPen® - increased heart rate Antihistamine – sleepiness

Albuterol/Levalbuterol: increased heart rate, shakiness Other:_____

HEALTH CARE PROVIDER (HCP) ORDERS – NON Emergency Medications

Name of Medication	Dosage	Methods of Administration	Time of Day or When to be Taken

Diagnosis or reason for medication: _____

If given PRN, specify the length of time between doses and signs of when to give:_____

Possible side effects of medication:_____

Emergency procedure in case of serious side effects: _____

HCP's Signature: _____ Date: _____

HCP's Name: _____ HCP's Address:

Phone and FAX: _____

PARENT/GUARDIAN PERMISSION

The medication is to be furnished by me in the original container, labeled by the pharmacy with the name of the medicine, amount to be taken, and the time of day to be taken. The Health Care Provider's name is on the label. I understand that my signature indicates my understanding that reasonable care will be exercised in administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the licensed health professional's directions. If medication remains after the course of treatment, I will collect the medication from the school or understand that it will be destroyed.

State law requires students to have medication, with orders, at school prior to attending in accordance to RCW 28A.210.320

Signature of Parent/Guardian: _____ Date: _____

Note: The district endeavors to maintain consistent & safe medication storage temperature while medication is at school; this however cannot be guaranteed. The district cannot provide replacement of medication due to power failures or acts of nature.

This authorization is good for the current school year only

EDMONDS SCHOOL DISTRICT NO. 15
LYNNWOOD, WA 98036-7400
Educational Health Services

ADMINISTRATION OF MEDICINES AT SCHOOL

PROCEDURE FOR PARENT/GUARDIAN TO FOLLOW IF IT IS ESSENTIAL THAT STUDENT RECEIVE MEDICATION DURING TIME OF ATTENDANCE AT SCHOOL AND STUDENT NEEDS HELP FROM STAFF:

1. Have your Health Care Provider complete the front page of this form. Return it to school. Instructions must be specific and not depend on school staff judgment.

2. Provide medication in a container with the original label from the Health Care Provider or pharmacist. The label must have your child's name, the name of the medication, dosage and time of administration.

3. To prevent unsupervised access of your child or other students to the medication, personally deliver it to the school.

4. You will want to maintain a record of the use of medication and expiration dates (if applicable) so that you will know when to replenish the school supply.

5. Parent/guardians have the option to take medication home for safe-keeping over breaks. Be aware, for students with Life Threatening Conditions, that if this choice is selected, the medication must be back on the school site **before the start of the school day** on the first day back from break:
   - for student safety
   - to comply with the State's Life Threatening Conditions Law (RCW 28A.210.320)
   - **and for the student to be able to attend school**.

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