Parent Consent and Authorized Healthcare Provider Authorization for Management of Anaphylaxis at School and School-sponsored Events

Pupil:	**DOB:**	**Date:**
School:	**Teacher/Rm:**	**Grade:**
Medical office:	**Patient Identification #:**	

1. Allergens or factors causing anaphylactic reaction:

_____

_____

2. Pupil's most common signs and symptoms:

_____

_____

3. Pupil's typical reaction time after allergen exposure:

_____

4. Date of last anaphylactic reaction: _____

5. Medication—Epinephrine auto-injector:

☐ EpiPen 0.3mg ☐ EpiPen Jr. 0.15 mg

☐ Twinject 0.3mg ☐ Twinject 0.15mg

☐ Other: _____ _____ mg.

NOTE*: 911 emergency services will be called and pupil transported to emergency room if anaphylactic reaction occurs and is treated in school setting.*

6. Administer epinephrine when:

☐ Pupil has severe symptoms of anaphylaxis:

_____

☐ Pupil has definite exposure to allergen; No immediate symptoms noted.

☐ Pupil has any symptoms after suspected exposure to allergen

☐ Administer 2nd dose _____ min. after 1st dose if symptoms persist or recur

7. Medications administered after epinephrine

☐ **None**

☐ **Antihistamine:** _____

Dose: _____ Route: _____

☐ **Other medication:** _____

Dose: _____ Route: _____

Additional medical orders:

Authorized Healthcare Provider Authorization for Management of Anaphylaxis In School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name** _____**Signature** _____
Date_____ **Phone** _____ **Address** _____**City** _____**Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Supervising Physician Name _____ **Address** _____ **Phone** _____

☐ I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).

Parent Consent for Authorization and Management of Anaphylaxis in School Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the specialized physical healthcare service, anaphylaxis treatment, be administered to my (our) child in accordance with state laws and regulations. I (we) will:

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status or attending authorized healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Healthcare Plan (IHP).

Parent(s)/Guardian(s) Signature _____**Date** _____

_____ **Date**_____

Reviewed by school nurse (signature) _____ **Date** _____

☐ **School nurse has informed principal about SPHCS being provided for this pupil.**