

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 #:
<p>1. Allergens or factors causing anaphylactic reaction: _____</p> <p>2. Pupil's most common signs and symptoms: _____</p> <p>3. Pupil's typical reaction time after allergen exposure: _____</p> <p>4. Date of last anaphylactic reaction: _____</p> <p>5. Medication—Epinephrine auto-injector: <input type="checkbox"/> EpiPen 0.3mg <input type="checkbox"/> EpiPen Jr. 0.15 mg <input type="checkbox"/> Twinject 0.3mg <input type="checkbox"/> Twinject 0.15mg <input type="checkbox"/> Other: _____ mg.</p> <p>NOTE: 911 emergency services will be called and pupil transported to emergency room if anaphylactic reaction occurs and is treated in school setting.</p>	<p>6. Administer epinephrine when: <input type="checkbox"/> Pupil has severe symptoms of anaphylaxis: _____</p> <p><input type="checkbox"/> Pupil has <u>definite</u> exposure to allergen; No immediate symptoms noted.</p> <p><input type="checkbox"/> Pupil has <u>any</u> symptoms after suspected exposure to allergen</p> <p><input type="checkbox"/> Administer 2nd dose _____ min. after 1st dose if symptoms persist or recur</p> <p>7. Medications administered after epinephrine <input type="checkbox"/> None <input type="checkbox"/> Antihistamine: _____ Dose: _____ Route: _____ <input type="checkbox"/> Other medication: _____ Dose: _____ Route: _____</p>	
Additional medical orders:		
<p>Authorized Healthcare Provider Authorization for Management of Anaphylaxis In School Setting</p> <p>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.</p> <p>*Authorized Healthcare Provider Name _____ Signature _____ Date _____ Phone _____ Address _____ City _____ Zip _____</p> <p>*Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number _____ Supervising Physician Name _____ Address _____ Phone _____</p> <p><input type="checkbox"/> I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).</p>		
<p>Parent Consent for Authorization and Management of Anaphylaxis in School Setting</p> <p>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:</p> <ol style="list-style-type: none"> 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. <p>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).</p> <p>Parent(s)/Guardian(s) Signature _____ Date _____ _____ Date _____</p>		

Reviewed by school nurse (signature) _____ Date _____

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