School Administrative Unit #9

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Medication Order for Students with a History of Allergic Reactions

Name of Student: _____ **Date of Birth:** _____

ALLERGIC TO: _____

SEVERE SYMPTOMS after suspected ingestion or contact:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive coughing
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hive over body

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. CALL 911
3. Begin monitoring
4. Give additional medications
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthmatic

Or combination of symptoms from different body areas

MILD SYMPTOMS only:

One or more of the following:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professional + parent
3. If symptoms progress (see above) USE EPINEPHRINE
4. Begin monitoring

MEDICATION ORDER:

Antihistamine
Medication:_____
Dose:_____
Route:_____
Side Effects:_____

Epinephrine
Medication:_____
Dose:_____
Route:_____
Side Effects:_____

_____
Licensed Prescriber's Signature Date
Telephone:_____

_____
Please Print Name

Student has permission to self-carry? (Circle one) YES NO

PARENT/ GUARDIAN AUTHORIZATION

I hereby authorize the designated staff person or school nurse to administer the above medication as directed. In consideration for this services, I further agree that I will not hold liable, and will save harmless, the SAU 9 School District and/or any department or employee thereof for death or injury resulting from administration or assistance in the administration of the medication described above.

_____
Parent / Guardian Name (Printed)

_____
Parent / Guardian Signature Date

Date received at heath office: _____

RN Signature:_____