

EMERGENCY PLAN FOR BEE STINGS AND ALLERGY / ANAPHYLAXIS (SECONDARY TO FOOD ALLERGY)

Permission to Administer Emergency Medication for a Life Threatening Condition

Student:	Birthdate:	Physician:
School:	Teacher:	Physician Phone:

Student will be carrying an Epi-Pen on their person, authorized to self-administer: Yes No

Intervention:

Administer Epi-Pen per following instructions: _____
 Oral medication to be administered (include name, dosage, and form): _____

I certify that valid health reasons exist requiring that medication be administered during school hours or during such time that the student is under supervision of school officials.

I request and authorize that the above named student administer the identified medication in accordance with the instructions indicated for an emergency/life threatening condition. The medication may also be administered by trained school personnel.

Date of Signature Physician Signature
(Physician's Assistant's orders must be countersigned by supervising MD)

Telephone Number Name (Print or Type)

If Epi-Pen is not immediately available, staff should:

- **Call 911**
- **Stay with student**
- **Notify parents**

Symptoms of anaphylaxis include:

- | | |
|-------------------------------|------------------------------------|
| Hives/rash/itching | Sweating |
| Wheezing/difficulty breathing | Anxiety |
| Tachycardia (fast pulse) | Alteration impulse or respirations |
| Swelling | Tightness in the throat |
| Lightheadedness | Nausea / Vomiting |

THIS PORTION OF FORM IS TO BE COMPLETED BY THE PARENT GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the identified student above. I request and authorize the student and/or the trained school staff administer the emergency medication to the above-identified student.

I understand that my signature indicates that the school accepts no liability for untoward reactions when the medication is administered in accordance with the licensed health care provider's directions.

Parent/Guardian Signature

Date

Home Phone / Cell Phone

Work Telephone Number