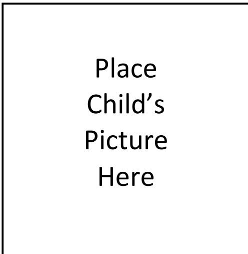
Authorization for Emergency Allergy Treatment



Student Name:_____________________________D.O.B.:__________Teacher:_________________

ALLERGY TO:____

Asthmatic: Yes* ☐ No ☐ *Higher risk for severe reaction

◆STEP 1: TREATMENT◆

Symptoms:		**Give Checked Medication***:** ***(To be determined by physician authorizing treatment)
▪ If a food allergen has been ingested, but *no symptoms*:		☐Epinephrine ☐ Antihistamine
▪ Mouth:	Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine ☐ Antihistamine
▪ Skin:	Hives, itchy rash, swelling of the face or extremities	☐Epinephrine ☐ Antihistamine
▪ Gut:	Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine ☐ Antihistamine
▪ **Throat:	Tightening of throat, hoarseness, hacking cough	☐Epinephrine ☐ Antihistamine
▪ **Lung:	Shortness of breath, repetitive coughing, wheezing	☐Epinephrine ☐ Antihistamine
▪ **Heart:	Thready pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine ☐ Antihistamine
▪ **Other:	____	☐Epinephrine ☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. **Potentially life-threatening.

DOSAGE

Epinephrine: Inject intramuscularly (circle one): EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: give____
Medication/dose/route

Other: give____
Medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆STEP 2: EMERGENCY CALLS◆

1. Call 911 (or Rescue Squad:________________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr._________________________________ Phone Number:__________________at____________________

3. Parents______________________________ Phone Number(s)______________________________________

4.Emergency contacts:

Name/Relationship	Phone Number(s)	
a.______________________________________	1.)____________________	2.)______________________
b.______________________________________	1.)____________________	2.)______________________

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature____ Date___________________

Doctor's Signature____ Date___________________

The Clifton School

Notice of Emergency Allergy Treatment

For Center Use

Child Full Name:____

Date and Time of Allergic Reaction:________________________________

Time Parent Notified by Phone:____________________________________

If noticeable allergic reaction occurred, describe the child's symptoms:

____
____
____

If noticeable allergic reaction occurred, describe what the child ingested that may have caused the reaction:

____
____
____

TREATMENT GIVEN:____

DOSAGE:____

RESPONSE:____

GIVEN BY:____

ADMINISTRATOR:____