ANAPHYLAXIS MEDICATION AUTHORIZATION (Med Form 4)

Bob Jones Academy

Must be completed by parent before medication can be brought to school.

Please print

School year _____ Date of birth _____

Student's name _____ Parent _____

Child is severely allergic to _____

Name of medication to be given at school _____

_____

Amount of medication to be given _____

Expiration date of medication _____

Physician's specific instructions for medication administration _____

_____

Child is asthmatic ☐ Yes ☐ No

Child is at high risk for severe reaction ☐ Yes ☐ No

Child's first symptoms may start as (check all that apply)

- ☐ Itching and swelling of the lips, tongue or mouth
- ☐ Shortness of breath, repetitive coughing and/or wheezing
- ☐ Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- ☐ Hives, itchy rash and/or swelling about the face or extremeties
- ☐ "Thready" pulse, passing out
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea

Call ***Rescue Squad*** (request Epinephrine)

Call mother at: Cell phone _____ Work phone _____

Call father at: Cell phone _____ Work phone _____

Physician's name _____ Office phone _____
(that prescribed this medication)

Do not hesitate to administer medication or call 911 even if parents cannot be reached.

Parent, please read carefully:

I understand that all medication will be provided by me in the original container, clearly labled with my child's name. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. I give the school nurse my permission to contact my child's physician's office to request medical information concerning my child. I am aware of the expiration date and will replace medication before it expires.

_____

Parent's Signature Date