BOB JONES ACADEMY

# Anaphylaxis Medication Authorization

***Must be completed by the Parent/Legal Guardian before a medication can be brought to school.***

**Please print**

Student's name_____ Date of birth_____

Parent/Legal Guardian_____ The child is severely allergic to_____

Name of the medication to be given at school_____

_____

Amount of the medication to be given_____

The expiration date of the medication_____

Physician's specific instructions for medication administration_____

_____

The child is asthmatic ☐ Yes ☐ No

The child is at high risk for severe reaction ☐ Yes ☐ No

## The child's first symptoms may start as (check all that apply)

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

Call ***911*** (request Epinephrine), then call parent/legal guardian:

Name_____ Cell phone_____ Work phone_____

Name_____ 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 labeled 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 the medication before it expires.

_____

Parent's/Legal Guardian's Signature Date

*This form is only valid if signed on or after July 1st for the upcoming school year.*