Heritage Christian Academy
MEDICATION AUTHORIZATION ORDER &
EMERGENCY PLAN FOR LIFE-THREATENING ALLERGIC REACTION

Student Name:	**Birthdate:**
Grade/Teacher:	**Sex: ☐ M ☐ F**

LICENSED HEALTH CARE PROVIDER (LHP) EMERGENCY MEDICATION ORDERS

(To be completed by the LHP)

Asthma: ☐Yes (high risk for severe reaction) ☐No

Severe Allergy to: _____

For the Following		**Give the following**		
For definite exposure, even if no symptoms OR for ANY symptoms if there is a likely exposure		☐Epinephrine	☐Antihistamine	☐Bronchodilator
OR				
For the Following Symptoms		Give the Following Medications		
Mouth:	Itching, tingling, or mild swelling of the lips	☐ Epinephrine	☐Antihistamine	☐ Bronchodilator
Skin:	Mild hives, itchy rash	☐ Epinephrine	☐Antihistamine	☐ Bronchodilator
Skin:	Severe hives, swelling of face or extremities	☐ Epinephrine	☐Antihistamine	☐ Bronchodilator
Gut:	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐Antihistamine	☐ Bronchodilator
Throat:	Tightening of the throat, hoarseness, hacking cough	☐ Epinephrine	☐Antihistamine	☐ Bronchodilator
Lungs:	Short of breath, repetitive coughing, wheezing	☐ Epinephrine	☐Antihistamine	☐ Bronchodilator
Heart:	Thready pulse, low blood pressure, fainting, pale	☐ Epinephrine	☐Antihistamine	☐ Bronchodilator

MEDICATION / DOSES

Epinephrine: ☐ Epinephrine 1:1000 USP (0.15mg) **OR** ☐ Epinephrine 1:1000 USP (0.3mg) **OR**
☐ Other: _____
Inject intramuscularly into upper outer thigh by trained staff members
☐ A second Epinephrine dose may be given ≥ _____minutes or more, if symptoms persist or reoccur.

Antihistamine: ☐ Liquid Benadryl/Diphenhydramine 12.5mg/5ml:_____tsp(s) **OR**
☐Benadryl/Diphenhydramine tabs/caps: _____mg **OR** ☐ Other:_____
Give one time orally if student is able to swallow safely

Bronchodilator: ☐ Albuterol Oral Inhaler _____ puffs by mouth **OR** ☐ Other: _____
Inhale _____puffs orally once. May repeat every _____ minutes _____ times, if symptoms persist.

LEVEL OF SELF CARE

☐ Student **May** self-carry medication at all times during the school day. They have been instructed on the proper indicated use, administration technique, dosage, and universal precautions for this medication.
☐ Student **May Not** self-carry medication. Emergency medication will be stored in the classroom/health room.

LHP SIGNATURE/INFORMATION

I request and authorize that the above-named student receive the above-identified medication(s) in accordance with the instructions indicated, beginning with the day _____ of _____, 20____ (not to exceed the current school year). There exists a valid health reason, which makes administration of the medication advisable during school hours.

➢LHP Signature: Date:

LHP Printed Name:

LHP Phone: LHP Fax:

Heritage Christian Academy School Nurse Signature:_____Date:_____

Student Name:	**Birthdate:**
Grade/Teacher:	

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

☐**ALLOW** my student to self-carry Epinephrine ☐**DO NOT** allow my student to self-carry Epinephrine

State law requires students to have medication, with orders, at school prior to attending in accordance to RCW 28A.210.320

☐I request this medication to be given as described in the Emergency Action Plan as ordered by the LHP.
☐I understand that 911 will always be called if the Epinephrine is used at school, and I must replace the Epinephrine before my student can return to school. And, if the school nurse is not available, Epinephrine WILL be given for ANY allergy symptoms or known ingestion. (e.g. field trip, after school activity, extended care, etc.)
☐When notified by school personnel that medication remains after the order has been withdrawn or student is no longer at the school, I will collect the medication from the school or understand that it will be destroyed.
☐My signature indicates my understanding that reasonable care will be exercised in administration of the medication. The school accepts no responsibility for adverse reactions when the medication is dispensed in accordance with the LHP's directions.
☐I understand this is a plan for a life-threatening condition and can only be discontinued, in writing, by a LHP.
☐I understand that if any changes are needed to this plan, it is the parent's responsibility to contact the school nurse.

All medication must come in the original, properly labeled container with instructions matching the Medication Authorization Order Form.

Parent/Guardian printed Name & Signature: Date:
➢

Mobile# Work# Home#

Student Signature (only if authorized to self-carry) Date:

THIS PORTION TO BE COMPLETED BY SCHOOL NURSE

Location of epinephrine:_____

EMERGENCY CARE PLAN – When in doubt, Give Epinephrine

For symptoms (front page) requiring Epinephrine administration:	For symptoms (front page) NOT requiring Epinephrine administration
1. INJECT EPINEPHRINE IMMEDIATELY Time given:_____ 2. CALL 911 3. Begin monitoring (see box below) 4. Give additional medications as ordered if student is able to swallow: antihistamine/bronchodilator 5. If symptoms do not improve, or they return, a 2nd dose of epinephrine may be administered ≥_____ minutes after the first dose.	1. Give antihistamine/bronchodilator as ordered 2. Stay with the student and watch closely for changes 3. If symptoms worsen, give epinephrine as ordered 4. Begin monitoring (see box below) 5. Call parent/guardian

MONITORING

☐ Stay with student ☐ Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side ☐ Monitor student and begin CPR if necessary ☐ Notify parent/guardian ☐ If ordered, a 2nd epinephrine dose can be given if symptoms persist or reoccur.	☐ Stay with student ☐ Notify parent/guardian ☐ Treat even if parent/guardian cannot be reached ☐ The severity of the reaction can change quickly. Past reactions do not predict future reactions ☐ Monitor student and begin CPR if necessary ☐ If symptoms worsen, give Epinephrine as ordered.

Heritage Christian Academy School Nurse Signature:_____Date:_____