Eastmont School District & Wenatchee School District

AUTHORIZATION FOR EMERGENCY MEDICATION MANAGEMENT AT SCHOOL

School: FAX:

Student: Birth Date: Grade:

Parent Section /*Seccion des Padres*

I request the designated staff member, administer the following medication in accordance with the healthcare provider instructions /*Yo pido que la enfermera o personal designado le administre el medicamento recetado de acuerdo con las instrucciones del medico*

I give my permission for the medication information to be shared with school staff on a need to know basis
Doy permiso que la siguiente información sea compartida con el personal escolar que necesite estar informado
☐ Yes/*Sí* ☐ No

I give permission for my child to carry this emergency medication
Doy permiso para que mi estudiante pueda cargar su medicamento de emergencia ☐ Yes/*Sí* ☐ No

I give permission for my child to self-administer this emergency medication.
Doy permiso para que mi estudiante pueda administrarse su propio medicamento de emergencia ☐ Yes/*Sí* ☐ No

_____ _____ _____ _____
Signature/Firma *Date/Fecha* *Phone #1 Números de teléfono* *Phone #2*

_ _ _ LICENSED HEALTH CARE PROVIDER TO COMPLETE SECTION BELOW _ _ _

Please complete for all students planning to use an inhaler at school in accordance with chapter 28A.210 RCW

Severity of asthma: ☐ Mild ☐ Moderate ☐ Severe

Name of Inhaler Medication	*Dosage*	*Route*	*Time of Day or Time Interval if PRN*

Further instructions (Possible reaction, etc.) _____

☐ Student may carry & self-administer inhaler ☐ Student has been instructed in the correct use of the inhaler

☐ Student does not demonstrate ability sufficient to self-carry or self-administer inhaler at school

- School Nurses recommend that a spacer is used with an inhaler

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Student has severe allergy to: _____

Describe symptoms in previous reactions: _____

Treatment for an Allergen Exposure or a Suspected Exposure

Symptoms may include one or more symptoms

Skin: hives, swelling in more than one area
Mouth: itching, swelling of lips, tongue or mouth
Throat: itching, sense of tightness, hoarseness
Lungs: shortness of breath, coughing, wheezing.
Gut: nausea, cramps, vomiting, and/or diarrhea
Heart: lightheadedness; dizziness, fainting

1. **Give Epinephrine IM Immediately**

Epinephrine auto-injector ☐ 0.15mg or ☐ 0.3mg
repeat 2nd Epinephrine after _____ min if the student has a 2nd Epinephrine injector.

2. Note the time the Epi was given.
3. Call 911, and inform that epi has been given.
4. Call the parent /guardian & remain with the student.

This student may carry their Epinephrine auto-injector at school. ☐ Yes ☐ No

This student is trained and capable to self-administer this emergency medication. ☐ Yes ☐ No

Medication order is valid for duration of current school year, which includes summer school.

_____ _____
Licensed Health Care Provider Signature *Printed LHCP Name*

_____ _____ _____
Date *Health Care Provider Phone* *FAX*

This new form is a collaboration between School Nurses from Eastmont School District and Wenatchee School District 01-19