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WHERE BIG FUTURES BEGIN

ALLERGY MEDICATION AUTHORIZATION FORM

Child's Name:	**Date of Birth:**
Type of Allergy:	**Age** _____**Weight**_____

Name of Medication:	Amount/Dose:
Start Date:	Stop Date:
Times to be Given: (see Care Plan)	Route: (example – injection)
Possible Side Effects:	Special Instructions:
Above information consistent with label?	Requires Refrigeration? □Yes □No

_____ _____
Licensed Health Professional Signature *Date*

_____ _____
Licensed Health Professional Name (Print) *Phone Number*

_____ _____
Custodial Parent/Guardian Signature *Phone Number*

_____ _____
Custodial Parent/Guardian Signature *Phone Number*

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EMERGENCY PLAN FOR ALLERGIC REACTIONS

Student's Name: _____ Date of Birth _____

Allergy to: _____

Asthma: □ Yes* □ No *□ High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION:

Systems	Symptoms
Mouth	itching & swelling of the lips, tongue, or mouth
Throat	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung	shortness of breath, repetitive coughing, and/or sneezing
Heart	"thread" pulse, "passing-out"

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation.

Action for ***minor*** reaction:

If symptoms are: _____

□ Administer: _____
Medication/dose/route

□ Call parent/guardian and health care provider

□ If condition does not improve within 10 minutes follow steps for severe reaction, listed below:

Action for ***severe*** reaction:

If symptoms are: _____

□ Administer: _____ **IMMEDIATELY**
Medication/dose/route

□ Call 9-1-1

□ Call parent or guardian

□ Call health care provider

_____ _____
Parent/Guardian Name (Print) *Phone*

_____ _____
Parent/Guardian Signature *Date*

_____ _____
Licensed Health Professional Name (Print) *Phone*

_____ _____
Licensed Health Professional Signature *Date*