Palo Alto
Unified School District

Medication Authorization
Allergic Reaction/Anaphylaxis Consent Form

School Year: _____ School _____ Fax _____

Student Name: _____ DOB: _____

Grade: _____ Wt.: _____

List All Allergies: _____ Asthma: ☐ Yes ☐ No

*This form **must be renewed annually**, **and** when there are any changes in treatment or medication during the school year.*

Physician Authorization — Complete Medication List Below *Mark* All That Apply

1 **Epinephrine Auto-Injector given by Injection:**

☐ Epipen JR/Auvi Q/Generic Epinephrine **0.15 mg** ☐ Epipen/Auvi Q/Generic Epinephrine **0.30 mg**

☐ Give for known allergen exposure even if no symptoms ☐ Give for likely allergen exposure for any symptoms

☐ A second dose of epinephrine may be given 5-10 minutes after the first dose, if symptoms persist or recur.

☐ Student to **carry medication and self-administer**. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication (Epinephrine Auto Injector).

☐ For **severe** allergic reaction symptoms, including shortness of breath, wheezing, repetitive cough, paleness, bluish cast, faintness, weak pulse, dizziness, tightness in throat, hoarseness, trouble breathing/swallowing, significant swelling of the tongue and/or lips, multiple hives over body, widespread redness, repetitive vomiting or severe diarrhea, or a combination of mild or severe symptoms, give:

☐ Epinephrine ☐ Antihistamine ☐ Inhaler

☐ For **mild** allergic reaction symptoms, including itchy/runny nose, sneezing, itchy mouth, few hives, mild itching, and mild nausea/discomfort, give:

☐ Antihistamine ☐ Inhaler

2 **Other Medications:**

**Antihistamine given by Mouth for allergy symptoms*

Benadryl (Diphenhydramine) ☐ 12.5 mg = 5 ml ☐ 25 mg = 10 ml ☐ 37.5 mg = 15 ml ☐ 50 mg = 20 ml

☐ Repeat dose every ____ hours

**Inhaler inhaled by Mouth for wheezing*

☐ Albuterol ☐ Levalbuterol ☐ Other: _____ Dose: ☐ 2 puffs or ☐ 4 puffs

☐ Repeat dose every ___ hours ☐ Use with spacer

☐ Student to **carry medication and self-administer**. The health care provider has confirmed that the student is capable of appropriate self-administration of the above medication (Inhaler).

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with states laws and regulations. Specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the credentialed school nurse.

_____ _____

Physician Name & Signature Date

_____ _____

Phone Fax

Clinic Stamp

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-4240 | Fax 650-833-4226

Updated 5/19/2017

Palo Alto
Unified School District

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Parent/Guardian Consent

I request that my child be allowed to take medication at school according to instruction from the above health care provider. I authorize school personnel to assist with this medication for my child as ordered from the above health care provider. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480).

I give consent to communication and exchange of information between PAUSD, the health care provider listed above, and the pharmacy listed on the prescription medication above regarding the health care provider's written statement or any other questions about the medication or medication administration.

I understand and agree to the following responsibilities regarding medication administration:

1. This form must be renewed whenever student's prescription changes and at beginning of each school year.
2. Prescription medication must be in a container labeled by the pharmacist or health care provider and will not be expired.
3. Non-prescription medication must be in the original container with the label intact.
4. An adult must bring the medication to the school health office and pick up any outdated or unused medication.
5. If the student will keep and self-administer an Epinephrine Auto-Injector, Parents/Guardians will provide a back-up to the school health office to keep in the event student forgets or cannot access theirs.
6. Pill splitting must be done by parent/guardian prior to providing medication to school officials.
7. Parents/Guardians provide all materials or necessary equipment (e.g. measuring spoon) for medication administration.
8. Students may not carry and self-administer medication unless authorization has been given by student, parent, and health care provider.
9. Parents will notify the school and provide new consent for any changes to the above authorization.
10. Any modifications or changes to the above authorizations may only be made after written notification is received from the health care provider.
11. I understand that 911 will be called in the event of a severe allergic reaction.

Parent/Guardian Signature | Date | Phone

Student/Parent Consent to Carry and Self-Administer Medication

Parent/Guardian Consent

I give my permission for my child to carry and self-administer the above medication as directed by the HCP, which I have also signed. I agree that my child has been trained and is competent to carry and self-administer this medication. I release the school district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering the Epinephrine Auto-Injector and/or the Inhaler. I understand this permission to carry and self-administer medication may be revoked by the school district if my child does not follow Universal Precautions, if my child is observed misusing the medication or medication supplies, or if having the student carry/administer this medication on campus creates an unsafe situation for students, staff or visitors to the school campus.

Parent/Guardian Signature | Date | Phone

Student Consent

I, _____, will be responsible for carrying, administering, and keeping my medication safe at all times. I know the signs and symptoms of an allergic reaction and am able to use my mediation as directed. I agree to self-administer my medication and/or manage medical equipment exactly as ordered by my health care provider. I understand that prescription medication must be in a container labeled by the pharmacist or health care provider. I understand that non-prescription medication must be in the original container with label intact. I understand that this medication/equipment is for my personal use only and must be kept in my possession. I will not show or share my medication with other students. I will immediately report to persons in charge if my medication is missing. I understand that I am responsible for maintaining supplies of my medication and to notify the school office if I run out of medication or supplies.

Student Signature | Date

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