ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2024-2025

Student Last Name	First Name	Middle	Date of birth ___/___/_____ MM DD YYYY	☐ Male ☐ Female
		Weight _____		
School			Grade	

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	Specify Allergy	Specify Allergy
☐ Allergy to	☐ Allergy to	☐ Allergy to

History of asthma?	☐ Yes (*If yes, student has an increased risk for a severe reaction*)	☐ No	**Does this student have the ability to:**	
History of anaphylaxis?	☐ Yes Date ___/___/_____	☐ No	Self-Manage *(See 'Student Skill Level' below)*	☐ Yes ☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes ☐ No
Treatment	Date ___/___/_____		Recognize/avoid allergens independently	☐ Yes ☐ No
History of allergy testing?	☐ Yes *(attach copy of results)* Date ___/___/_____	☐ No	Comments:	

Select In School Medications

1. SEVERE REACTION

- **CALL 911**, Immediately administer:

☐ **Epinephrine** Auto-Injector 0.15 mg

☐ **Epinephrine** Auto-Injector 0.3 mg (retractable devices preferred) intramuscularly into the anterolateral of thigh for the following symptoms:

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:_____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

- If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

Student Skill Level *(select the most appropriate option)*
☐ Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

2. MILD REACTION:

- Give antihistamine: Name:_____ Preparation/Concentration:_____ Dose:_____ Route: _____
  Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for the following symptoms:
  - Itchy nose, sneezing, itchy mouth
  - A few hives
  - Mild stomach nausea or discomfort
  - Other: _____
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine.

Student Skill Level *(select the most appropriate option)*
☐ Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

3. OTHER MEDICATION (e.g., inhaler/bronchodilator if child has asthma):

- Give Name:_____ Preparation/Concentration:_____ Dose: _____
  Route:_____ Frequency: Q_____ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:_____
If no improvement, indicate instructions:_____
Conditions under which medication should not be given: _____

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer

Practitioner's Initials _____

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Home Medications *(include over-the counter)*

_____

_____

Health Care Practitioner Name LAST (Please Print)	FIRST	Signature	Date ___/___/_____
Address		Tel. (___)___-____	Fax. (___)___-____
NYS License # **(Required)**	NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___		

PARENTS MUST SIGN PAGE 2 →

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM page 2
PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2024-2025

PARENTS/GUARDIANS FILL BELOW

By signing below, I agree to the following:

- I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner.
- I understand that:
    - I must give the school nurse my child's medicine.
    - All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will get another medicine for my child to use when he or she is not in school or is on a school trip.
        - Prescription medicine must have the original pharmacy label on the box or bottle.
    - I must immediately tell the school nurse about any change in my child's medicine or the doctor's instructions. I will give my child's school nurse a new medication administration form written by my child's health care practitioner.
    - The medication order in this medication administration form expires at the end of my child's school year. I will give my child's school nurse a new medication administration form at the beginning of every school year.

Student Last Name First	Date of Birth ___ / ___ / _____
Parent/Guardian Print Name:	Signature:
Date Signed ___ / ___ / _____	Cell Phone:
Other Phone:	Email:

FOR SELF ADMINISTRATION OF MEDICINE:

- I confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing, and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school.
- I consent to the school nurse or trained school staff giving my child medicine if my child is temporarily unable to carry and give him or herself medicine.

Parent/Guardian Print Name:	Signature:
	Date Signed ___ / ___ / _____