

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2022-2023

Student Last Name	First Name	Middle	Date of birth ____/____/____ MM DD YYYY	☐ Male ☐ Female
School			Weight _____	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	History of anaphylaxis? ☐ Yes Date ____/____/____ ☐ No	Does this student have the ability to: Self-Manage (See "Student Skill Level" below) ☐ Yes ☐ No
If yes, system affected ☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic	Treatment Date ____/____/____	Recognize signs of allergic reactions ☐ Yes ☐ No
History of allergy testing? ☐ Yes (attach copy of results) Date ____/____/____ ☐ No		Recognize/avoid allergens independently ☐ Yes ☐ 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.
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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.
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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.
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Home Medications (include over-the counter)

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

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PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year 2022-2023

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:
 - o I must give the school nurse my child's medicine.
 - o 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.
 - o 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.
 - o 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 ____ / ____ / ____