TORRANCE UNIFIED SCHOOL DISTRICT
PHYSICIAN'S AUTHORIZATION FOR MANAGEMENT OF ANAPHYLAXIS
AND EPINEPHRINE ADMINISTRATION AT SCHOOL

School _____ Health Office (310) _____ Fax (310) 972-_____

TO BE COMPLETED BY PARENT:

_____ _____ _____ _____
Last Name of Student, First Name | Date of Birth | Grade | Students in Grades K-5: Teacher/Room

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER*:

1. Allergens or factors causing anaphylactic reaction: _____
2. Student's most commons signs and symptoms: _____
3. Student's typical reaction time after allergen exposure: _____
4. Date of last anaphylactic reaction: _____
5. Medication to be given before Epinephrine? □ Yes □ No If yes, name of medication: _____
6. Medication to be given after Epinephrine? □ Yes □ No If yes, name of medication: _____

MEDICATION ORDERS TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER*:

Name of Medication	Dosage	Route/Frequency	Indications or Symptoms (please be specific)
Antihistamine: ☐ Benadryl (Diphenhydramine) ☐ Zyrtec (Cetirizine) ☐ Other: _____	_____ml liquid (12.5mg/5ml) _____12.5 mg chewable tablet(s) _____25mg tablet/capsule(s)	Route: by mouth Frequency: _____ _____	_____ _____
Epinephrine: ☐ EpiPen® or generic epinephrine auto-injector ☐ Auvi-Q auto-injector ☐ **Neffy**® nasal spray or generic equivalent	☐ 0.15 mg injection ☐ 0.30 mg injection ☐ 2mg nasal spray ☐ ___mg nasal spray	☐ IM in outer mid-thigh ☐ Other injection site: _____ ☐ In the nostril/ nasally	**Administer Epinephrine when:** ☐ Student has severe symptoms of anaphylaxis ☐ Student has **definite** exposure to allergen ☐ Student has **any** symptoms after suspected exposure to allergen ☐ Administer 2nd dose ___ minutes after 1st dose if symptoms persist or recur

TO BE COMPLETED BY SCHOOL STAFF UPON RECEIPT OF MEDICATION:

- Medication received matches physician's order (name, dose form, dosage, unopened for OTC) _____ (Initial)
- Medication(s) and quantity received: _____

_____ _____ _____ _____
Parent/Guardian Signature | Date | Staff Signature | Date

TO BE COMPLETED BY SCHOOL STAFF UPON RETURN OF UNUSED MEDICATION:

- Medication(s) and quantity returned: _____

_____ _____ _____ _____
Parent/Guardian Signature | Date | Staff Signature | Date

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Last Name of Student, First Name _____ Date of Birth _____ Grade _____ Students in Grades K-5: Teacher/Room _____

TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER (CONTINUED):

Additional medical orders/special instructions: _____

Possible adverse side effects of epinephrine: _____

NOTE: 911 Emergency services will be called and the student will be transported to the emergency room if anaphylactic reaction occurs and is treated in the school setting.

There may be circumstances where it is important for the student to have the medication on their person:

- ☐ Yes, student is authorized to carry, and is able to self-administer epinephrine independently (health care provider initials:__)
- ☐ Yes, student is authorized to carry, but keep a backup dosage in the Health Office (health care provider initials:__)
- ☐ No, Health office is best location, student requires supervision

Authorized Health Care Provider* Authorization for Management of Anaphylaxis in the School Setting

My signature below provides authorization for the written orders on pages 1 and 2. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by an unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

Office Stamp (required)

_____
Authorized Health Care Provider Signature Date

_____
Address City Zip Code

(_____)_____ (_____)_____
Telephone Fax

Furnishing number (Nurse Practitioner, Physician Assistant, and Nurse Midwife): _____

Supervising Physician Name: _____Phone: (_____)_____

Address _____ City_____ State_____ Zip_____

*Authorized Health Care Provider includes California-licensed physicians and surgeons, dentists, optometrist, podiatrists, nurse practitioners, and physician assistants or California-certified nurse midwives.

Parent Consent for Authorization and Management of Anaphylaxis in the School Setting:

I (we) the undersigned, the parent(s)/guardian(s) of the above named student, request that the specialized physical healthcare service, anaphylaxis treatment, be administered to my (our) child by designated school personnel in accordance with state laws and regulations. I (we) will provide the necessary supplies and equipment, notify the school nurse if there is a change in child's health status or attending authorized healthcare provider, and notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization. I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary. I (we) understand that I (we) will be provided a copy of my child's completed Individualized School Health Plan (ISHP).

_____ _____ _____
Parent / Guardian Signature Parent / Guardian Signature Date

Reviewed by District Nurse: _____ Date: _____