

<input type="checkbox"/>	Fennville Public Schools
<input type="checkbox"/>	Hamilton Public Schools
<input type="checkbox"/>	Holland Christian Schools
<input type="checkbox"/>	Holland Public Schools
<input type="checkbox"/>	West Ottawa Public Schools

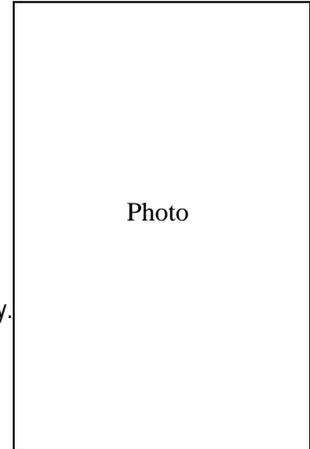


School Nursing Life-Threatening Allergy IHP

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN

I, the parent/guardian of _____ date of birth _____
 request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.



As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours.
And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.
5. I give permission for my child to self administer rescue medication if approved by physician

Signature of

Parent/Guardian: _____ **Relationship:** _____ **Date:** _____

ALLERGIES: _____

WEIGHT: _____ **Asthma:** () yes – higher risk for severe reaction () no
 () If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten
 () If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Signs and Symptoms of an Allergic Reaction:

- | | |
|----------|--|
| MOUTH: | itching, swelling of lips and/or tongue |
| THROAT*: | itching, tightness/closure, hoarseness, trouble breathing/swallowing |
| SKIN: | itching, hives, redness, swelling |
| GUT: | vomiting, diarrhea, cramps |
| LUNG*: | Shortness of breath, cough, wheeze |
| HEART*: | weak pulse, dizziness, passing out, pale, faint |

****The Severity of Symptoms Can Change Quickly and Progress to a Life-Threatening Situation. Do not depend on antihistamines to treat a severe reaction. Use Epinephrine.***

1. MEDICATIONS: () If checked, OK for student to carry/self-administer.
 () Epinephrine 0.15mg () Epinephrine 0.3mg
 () Antihistamine- name/dose _____

2. Call 911

3. Parent/guardian/emergency contact: #1 _____ phone number
 #2 _____ phone number

Comments: _____

Physician Signature: _____ **Date:** _____

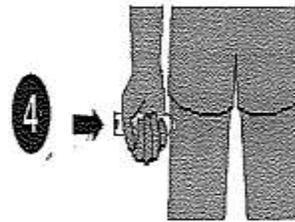
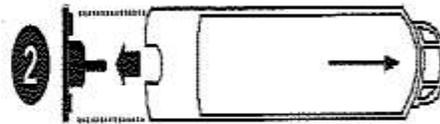
Physician's Name (printed): _____

Phone Number: _____ **FAX Number:** _____

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EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.

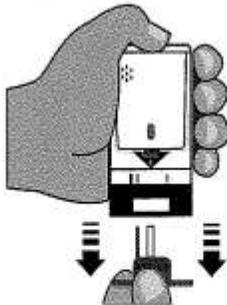


How to use Auvi-Q™ (epinephrine injection, USP)

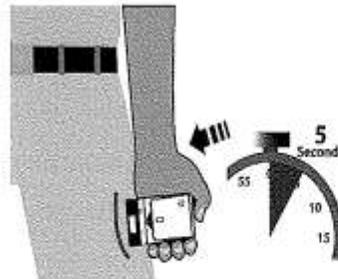
In case of an anaphylactic reaction:

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.

- 1** Pull off the RED safety guard.



- 2** Place black end against outer thigh, then press firmly and hold for 5 seconds.



After using Auvi-Q, seek emergency medical attention immediately.