School District of Monticello

Consent for Allergy Medications

Student ___________________________________ Grade _______________ DOB ___________________

To be completed by Health Care Provider:

Epinephrine: ❑ 0.3mg IM or ❑ 0.15mg IM

Antihistamine: ____

Other medication: ____

Student may self- carry and self- administer medications: ❑ Yes ❑ No (Middle and High School students only)

Provider signature _____________________________________

Date _____________________ Phone number ___________________________

To be completed by parent/guardian:

I give my child permission to carry and self-administer his/her allergy medication(s). I believe he/she is responsible to keep this medication in his/her possession and control its use. ❑ Yes ❑ No

I authorize trained staff to administer and/or assist my child in taking this medication at school and to communicate with the healthcare provider, if necessary. I further agree to hold the School District of Monticello, its employees, and agents who are acting within the scope of their duties, harmless in any and all claims arising from administration of this medication at school to my child. I authorize the release of this information to appropriate school personnel and classroom teachers.

Parent/Guardian signature ________________________________

Date _____________________________ Phone number _____________________________________

***PLEASE COMPLETE ALLERGY EMERGENCY ACTION PLAN ON BACK OF THIS PAGE.**

School District of Monticello

Allergy Emergency Action Plan

Student ____ Grade _________ DOB ________________

ALLERGIC TO: ____

History of Anaphylaxis: ( ) Yes ( ) No

Step 1: IMMEDIATE TREATMENT	
SYMPTOMS:	GIVE CIRCLED MEDICATION:
If a bee sting has occurred but *no symptoms*:	Epinephrine Antihistamine
If a food allergen has been ingested but *no symptoms*:	Epinephrine Antihistamine
If the following allergy symptoms are observed:	
• Mouth: itching, tingling, or swelling of lips, tongue, or mouth	Epinephrine Antihistamine
• Skin: hives, itchy rash, swelling of face or extremities	Epinephrine Antihistamine
• Gut: nausea, abdominal cramps, vomiting, or diarrhea	Epinephrine Antihistamine
• ***Throat**: tightening of throat, hoarseness, hacking cough	Epinephrine Antihistamine
• ***Lungs**: shortness of breath, repetitive coughing or wheezing	Epinephrine Antihistamine
• ***Heart**: weak or thread pulse, low blood pressure, fainting, pale or blueness of skin	Epinephrine Antihistamine
• ***Other**: __________________________________	Epinephrine Antihistamine
• If reaction is progressing (several of the above areas affected) give:	
***Potentially life-threatening.**	
***The severity of symptoms can change quickly.**	

Further action:

1. **If epinephrine administered, call 911 and parents**.
2. If antihistamine administered, call parents and continue to monitor.

Provider signature/date: ____

Parent signature/date: ____

School RN signature/date: ____