

**AUTHORIZATION FOR EMERGENCY TREATMENT**

(Picture of Student)

Student's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Grade: \_\_\_\_\_

Allergic to: \_\_\_\_\_

1.If you suspect that a food allergen has been ingested (or insect sting), immediately determine the symptoms and treat the reaction as follows:

**Symptoms**

**Give Medication checked "X"\***

Mouth Itching, tingling, or swelling of lips, tongue, mouth ( ) Benadryl ( ) EpiPen

Skin Hives, swelling on face or extremities, itchy rash ( ) Benadryl ( ) EpiPen

Gut Nausea, abdominal cramps, vomiting, diarrhea ( ) Benadryl ( ) EpiPen

Throat Tightening of throat, hoarseness, hacking cough ( ) Benadryl ( ) EpiPen

Lung Shortness of breath, repetitive coughing, wheezing ( ) Benadryl ( ) EpiPen

Heart Thready pulse, passing out, fainting, pale, blueness ( ) Benadryl ( ) EpiPen

General: Panic, sudden fatigue, chills, fear of impending doom ( ) Benadryl ( ) EpiPen

If a food allergen has been ingested, but no symptoms (X) Benadryl ( ) EpiPen

If a reaction is progressing (several of the above areas affected)( X ) Benadryl ( X ) EpiPen

**Medication Doses:**

**Antihistamine (liquid diphenhydramine, Benadryl):**

Give \_\_\_\_\_ Teaspoon(s), \_\_\_\_\_ cc ( \_\_\_\_\_ mg) by mouth.

**Epinephrine**

**EpiPen [EpiPen \_\_\_\_\_ ( \_\_\_\_\_ mg) injected once into upper outer thigh**

Epinephrine injection may need to be repeated if the child's symptoms persist or get worse.

Call 911 (or Ambulance service and phone number: \_\_\_\_\_)

State that the child had a severe allergic reaction, and additional epinephrine does may be needed.

**Additional contact information:**

Nearest Hospital \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Allergist Name \_\_\_\_\_ Phone \_\_\_\_\_

Pediatrician Name \_\_\_\_\_ Phone \_\_\_\_\_

Parent Name (other contacts) and Contact Numbers:

Name \_\_\_\_\_  
Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Name \_\_\_\_\_  
Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Other allergies, medication allergies, medical conditions \_\_\_\_\_ Approximate weight \_\_\_\_\_ lbs

**DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED!**

- Additional boxes may be checked depending upon specific patient history

\_\_\_\_\_  
**Parent Signature / Date**

\_\_\_\_\_  
**Physician's Signature / Date**