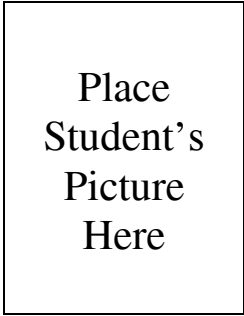


Valid for School Year	
_____ to _____	
Epinephrine Auto Injector	_____
	Expiration date
Antihistamine	_____
	Expiration date

POWAY UNIFIED SCHOOL DISTRICT
 15250 Avenue of Science, San Diego CA 92128



**SUGGESTED PROCEDURE IN CARING FOR STUDENTS WITH
 POTENTIAL ANAPHYLACTIC REACTION**

STUDENT NAME _____ **BIRTHDATE** _____

SCHOOL _____ **GRADE** _____

ALLERGY _____

Physician:
 Please provide the following specific instructions to assist our Health Technician (or school staff) in providing emergency care as needed during school hours. Although our credentialed school nurses are not at the school, indirect supervision will be provided from the central office. 911 will be called when epinephrine is administered.

TREATMENT:

Symptoms:

- If an exposure incident has occurred, but no symptoms
- Mouth - Itching, tingling
- Mouth – Swelling of lips, tongue, mouth
- Skin - Hives, itchy rash
- Skin – Swelling of the face or extremities
- Gut - Nausea, abdominal cramps, vomiting, diarrhea
- Throat* - Tightening of throat, hoarseness, hacking cough
- Lung* - Shortness of breath, repetitive coughing, wheezing
- Heart* - Thready pulses, low blood pressure, fainting, pale, blueness
- Other:*

Give Checked Medication

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
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| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. *Potentially life threatening.

Dosage:

Epinephrine: inject intramuscularly Adult - 0.3 mg. Junior/Child - 0.15 mg.

Antihistamine: _____ dose: _____ mg. _____ ml.

Other: _____ dose: _____ mg. _____ ml.

Additional Comments: _____

This portion to be completed by a physician licensed in the State of California.

PHYSICIAN'S SIGNATURE: _____ **Date** _____

Phone _____ **Fax** _____ **CA Med. License#** _____

I have read and accept conditions set forth by Poway Unified School District for treatment of Anaphylaxis (see page 2).

PARENT SIGNATURE: _____ **Phone** _____ **Date:** _____

POWAY UNIFIED SCHOOL DISTRICT
13626 Twin Peaks Road, Poway, California 92064-3098

**PARENT AUTHORIZATION FOR
SPECIALIZED PHYSICAL HEALTH CARE SERVICE**

I understand that only personnel meeting the requirements of California Education and Administration Codes will be performing the above mentioned health care service and will be using only the standardized procedure approved by our physician.

I will provide the medicine(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement.

I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

To facilitate the foregoing, I hereby grant permission for the exchange between our physician and the Poway Unified School District of that confidential medical information contained in my child's records necessary to accomplish this service.

I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change in or cancellation of the procedure.