



GREER MIDDLE COLLEGE CHARTER HIGH SCHOOL

HOME OF THE BLAZERS

**AUTHORIZATION FOR ANAPHYLAXIS MEDICATION AT SCHOOL
(MUST BE SIGNED BY LICENSED HEALTH CARE PROVIDER AND PARENT/LEGAL GUARDIAN)**

School Year: _____

Please Print

Student's Name: _____ Birthdate: _____

Student is SEVERELY allergic to:

Medication to be administered at school:

- Antihistamine dose: _____ Route: Oral
- Epinephrine Auto Injector dose: 0.15mg 0.30mg to be given intramuscularly
- Epinephrine Nasal Spray dose: 1mg 2mg to be given intranasally
- Other: _____

Licensed Health Care Provider specific instructions for medication administration (example: give antihistamine prior to epinephrine):

Student's first symptoms may start as (check all that apply):

- | | |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Itching and swelling of the lips, tongue or mouth | <input type="checkbox"/> Hives, itchy rash and/or swelling around the face or extremities |
| <input type="checkbox"/> Itching and/or a sense of tightness in the throat, Hoarseness and hacking cough | <input type="checkbox"/> Nausea, abdominal cramps, vomiting and/or diarrhea |
| <input type="checkbox"/> Shortness of breath, repetitive coughing and/or wheezing | <input type="checkbox"/> "Thready" pulse or passing out |

Self-Carry/Self-Monitor:

The student has orders from a licensed health care provider to self-carry/self-monitor this medication.

Yes No

This student is to self-administer and self-monitor this medication while at school. Training has been completed by the licensed health care provider and the student has demonstrated competency in self-monitoring and self-administration of this medication. Medication must be with the student during school sponsored activities, in transit to and from school sponsored activities and during, before or after-school activities on school property. The parent is aware that they cannot hold the school responsible for any adverse outcome of this action.

Printed Name of Licensed Health Care Provider: _____ Phone: _____

Licensed Health Care Provider Signature: _____ Date: _____
(By signing this form, I am verifying that I have assessed this child and agree with the above treatment.)



GREER MIDDLE COLLEGE CHARTER HIGH SCHOOL

HOME OF THE BLAZERS

Student Name: _____

Field Trips: (The school will provide training for staff at the school to assist your child if needed).

- The student has permission from the physician to self carry and self monitor the medication and will be responsible for having medication available for trips off campus.
- The teacher in charge of the field trip will additionally be trained and have responsibility for administering medication if needed.

Bus Transportation:

- Yes, The student must have his/her anaphylaxis medication available on the bus.
- No, The student does not need his/her anaphylaxis medication available on the bus.

Parent/legal guardian please read carefully and sign below if you agree to the following:

- ❖ I understand that all medication will be provided by me in the original container, clearly labeled by the pharmacy with my child's name.
 - ❖ I will provide all necessary supplies/medication and notify the school of changes in condition or prescribed treatment plan. **I will notify the school if the medication is discontinued or the dosage has been changed.**
 - ❖ Permission is granted to the principal/and or school nurse to share this information with individuals who have responsibility for my child.
 - ❖ I give the school nurse and/or designee permission to contact the licensed health care provider's office to request medical information concerning my child.
 - ❖ I am responsible for replacing medication before the expiration date.
 - ❖ If the licensed health care provider authorizes my child to carry his/her medication during the school day, I understand that I cannot hold the school responsible for any adverse outcome of this action.
 - ❖ The school is not liable for any injury arising from administration of medication authorized by an IHP (Individual Health Plan) or licensed health care provider. As a parent/guardian, I shall indemnify and hold harmless the school against a claim arising from administration of medication authorized by an IHP or licensed health care provider.
-
- My student has orders from the licensed health care provider to self carry or self monitor this medication.
 - My student has been trained by the licensed health care provider and has demonstrated competency.

Parent/legal guardian signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Phone: _____

**Please do not hesitate to administer medication or call 911.
Alert EMS to possible allergic reaction.**