SEVERE ALLERGY ALERT FORM

This form must be completed by a parent/legal guardian or independent student when a student's attendance at school is affected by a dangerous, life-threatening allergy. The information gathered in this form must be reviewed (and confirmed or updated) annually or sooner if the student's condition changes.

STUDENT'S NAME: ______________________________

ALLERGY – DESCRIPTION

The student has a **DANGEROUS**, life-threatening allergy to the following:

____

____

and all substances containing them in any form or amount, including the following kinds of items:

____

____

____

Place Student's Photo Here

AVOIDANCE

The key to preventing an emergency is ABSOLUTE AVOIDANCE of these allergens at all times.

GENERAL PRECAUTIONS

____

If medical condition is an allergy, please advise:

a) Allergy Specialist: ______________________ Phone: ______________

b) Eating Rules (if any): ______________________

c)

Mild Attack Symptoms	Moderate Attack Symptoms	Severe Attack Symptoms

Medical procedure to be followed due to medical condition:

a) ______________________________

b) ______________________________

c) ______________________________

d) ______________________________

EMERGENCY MEASURES

- Get **EpiPen® (epinephrine)** or other **Medication** and administer immediately.
- **HAVE SOMEONE CALL AN AMBULANCE** and advise of need for an EpiPen® (epinephrine).
- Unless student is resisting, lay student down, tilt head back and elevate legs.
- Cover and reassure the student.
- Record the time at which **EpiPen® (epinephrine)** was administered.
- Have someone call the parent.
  If the ambulance has not arrived in 10-15 minutes, and breathing difficulties are present, administer a second **EpiPen® (epinephrine)**.
- Even if symptoms subside, students require medical attention because there may be a delayed reaction; take the student to the hospital immediately in the ambulance.
- If possible, have the parent or a school staff member accompany the student to the hospital.
- Provide ambulance and/or hospital personnel with a copy of the *Severe Allergy Alert Form* for the student and the time at which the **EpiPen® (epinephrine)** or **Medication** was administered.

I understand why I have been asked to disclose the above student's identifying information and I am aware of the risks or benefits of consenting or refusing to consent to the disclosure. I voluntarily give the school consent to place a copy of this form in the student's cumulative student record, post this form including the student's picture in appropriate location within the school, take the Emergency Measures and share this information, as necessary, with the staff of the school and health providers.

Name of Parent/Guardian or Independent Student (please print)	Signature of Parent/Guardian or Independent Student	Date:

ADMINISTERING PRESCRIPTION DRUGS TO STUDENTS

Refer to AP 316-1, Medical procedure to be followed due to medical condition.

Student's Name: ______________________________

Name of Medication: ______________________________

Purpose of Medication: ______________________________

Amount to be Administered: ______________________________

Administration Time: ______________________________

Possible Side Effects: ______________________________

Storage Instructions: ______________________________

Termination Date for Administration of Medication: ______________________

Student's Ability to Self-Administer: ______________________

I confirm that I have the authority to sign this consent and will inform any other parent or guardian of the contents of this consent and the fact it has been signed.

______________________ ______________________
Parent/Guardian Signature Date

Doctor's note confirming above information must be attached (copy to Student Record) OR the doctor can sign this form.

Date Doctor's note verified: ______________________ Refer to AP 316-1

The student's physician affirms that administration of medication to the student as requested by the parent is within the competence of an adult untrained in medical procedures.

______________________ ______________________
Doctor's Signature Date

Notes:

- Contact parent if extra dose is required (i.e. student forgot to take morning dose at home).
- All medication should be kept in an appropriately secure manner.
- Principal must review and initial the Medication Administration Record on a regular basis.