PARENT AUTHORIZATION & MD ORDERS FOR SEVERE ALLERGIC REACTION

Student Name:	DOB:

As the parent or guardian of the above referenced student, I authorize the administration of epinephrine for severe allergic reaction per MD order and nursing protocol.

I understand that:

- Administration of epinephrine is done only by designated persons who have completed the Severe Allergic Reaction training as per ORS 433.8433.800-830 and received specific training from a Registered Nurse as per OAR 851-047-0040.
- The prescription label must read **"Administer immediately upon signs of anaphylaxis" or " Administer immediately upon exposure to allergen"** or written orders must be provided by an **Oregon** licensed physician.
- By signing this form I authorize the exchange of information between the district nurse, school personnel and my child's health care provider for the purposes of allergy management in the school setting.
- This authorization is valid for one year beyond the signed date.
- I am responsible to bring all necessary supplies and medications to school for my student and any medications not picked up by the last day of school will be disposed of.

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Signature of parent Date

School Protocol includes:

- Observe student for signs of anaphylaxis
- Administer medications as ordered
- Immediately call EMS/9-1-1
- Continued observation of student for progression of symptoms and assessment of pulse and airway

OREGON LICENSED MEDICAL ORDERS
[to be completed by Oregon Licensed Physician (MD, NP, DO, PA, ND) only]
(orders valid for one year from signed date unless changed by provider)

Provider:____Fax:____________________

The above referenced student is severely allergic to (specify allergens) :

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Administer Auto-injector of Epinephrine ☐ 0.15mg **OR** ☐ 0.3mg IM

☐ **IMMEDIATELY** upon exposure to allergen -OR- ☐ **ONLY** upon signs and symptoms of anaphylaxis

☐ This student may self-carry/administer epinephrine auto-injector

Antihistamines:

☐ Administer __________mg of ____________________________PO IMMEDIATELY upon exposure to allergen(s).

☐ Administer __________mg of ____________________________PO SUBSEQUENT to epinephrine administration

☐ ____

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Signature of provider Date: