

ROCKLIN ACADEMY

Parent Consent and Healthcare Provider Authorization For Management of Anaphylaxis at School “Severe Allergic Reaction” Individualized School Healthcare Plan (ISHP)

Student Name _____ Birth Date _____ Grade _____

Address _____ Home Phone _____ Work Phone _____

PARENT CONSENT

I(We), the undersigned, the parent(s)/guardians of the above named pupil, request the following for the Management of Severe Anaphylaxis/Allergic reaction in school be administered to our(my) child in accordance with the California Education Code 49423.5.

I will: 1. Provide all medication, supplies, and equipment.

2. Notify the school if there is a change in the pupil’s health status or attending physician.

3. Notify the school immediately and provide new consent for any changes in doctor’s orders.

4. I ACKNOWLEDGE IF MY STUDENT CARRIES AND ADMINISTERS HIS/HER OWN MEDICATION IT MUST BE ON HIS/HER PERSON IN ORDER TO ATTEND A FIELD TRIP.

I authorize the school to communicate with the Authorized Health Care Provider when necessary in regards to this specific medication and medical condition. I will be provided with a copy of my child’s completed ISHP.

Parent/Guardian

Signature _____ DATE _____

Health Care Provider Authorization For the Administration of Medication by School Personnel

1. Allergic Reaction to: _____

Asthmatic Yes No

(Asthmatics are at high risk for severe reaction)

2. Medication: _____

3. Dose: _____

4. Method of Administration: _____

(See next page for more instructions)

5. Seek emergency care and administer medication for the following symptoms:

- **Mouth:** itching and swelling of the lips, tongue or mouth
- **Throat:** itching and or sense of tightness in the throat, hoarseness and hacking cough
- **Skin:** hives, itchy rash, and/or swelling about the face or extremities
- **Abdomen:** nausea, abdominal cramps, vomiting, and /or diarrhea
- **Lung:** shortness of breath, repetitive coughing, and /or wheezing
- **Heart:** “thready” pulse, “passing out”

The severity of the symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

- Call 911 at the beginning of the crisis**
- Administer the medication as ordered**
- Ensure adequate airway**
- Perform CPR if needed**
- Call Parent**
- Assist paramedics as needed**

Authorized Consent for Management of Severe Anaphylaxis/Allergic Reaction at School

My signature below provides the authorization for the above written orders. I understand that all procedures will be implemented in accordance with CA state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

1. I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and administer the medication by him/herself.
2. It is my professional opinion that _____ should not carry or administer his/her medication by him/herself.

Physician's

Signature: _____ **Date** _____

Address: _____ **Telephone:** _____

Principal's Signature: _____ Date: _____