

School Nurse Signature: _

HEALTH CARE PROVIDER EPINEPHRINE REQUEST AND TREATMENT PLAN FOR ANAPHYLAXIS

The symptoms of anaphylaxis may include breathing tramps, nausea/vomiting, dizziness, swelling away The treatment plan for preventing/treating anaphylaxis is exposed to allergen and/or exhibits and period in Epinephrine auto-injector 0.3 mg IM Epinephrine auto-injector 0.15 mg IM Epinephrine Intranasal mg Repeat dose of epinephrine to be given if Table 1911 at the time epinephrine is given and note that the student also has asthma and may be at high one see separate orders for asthma medication. Student and parent/guardian have been instructed in Student may carry the epinephrine as ordered. Student may self-administer the epinephrine as ordered. Student may self-administer the epinephrine as ordered. This AUTHORIZATION I Parent/Guardian's Permission I request that the school nurse, principal, or designate care providers and to administer to my child, (name of child) minister as indicated above, the medication prescrib school year. The medication is to be furned provider with the name of the medicine, the amount on the label. I understand that my signature indicates when the medication is administered, or my child self-	difficulty, facial/throat swelling from the site of a bee sting in the site	ng or tingling, hives, rash, itching, stomaching, and
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		hool accepts no liability for untoward reactions
har and and representation that recollection represents at the	s my understanding that the sci	the health care provider's directions. If notified
by school personnel that medication remains at the		Il collect the medication from the school or
understand that it will be destroyed. I am the pare	administers, in accordance with t	child named.
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Phone Contacts: HomeCell	administers, in accordance with t end of the school year, I wil nt or the legal guardian of the	Date:
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