White River School District No. 416
240 North A Street * PO Box 2050 * BUCKLEY WA 98321 * 360-829-0600

HEALTH CARE PROVIDER EPINEPHRINE REQUEST & TREATMENT PLAN FOR ANAPHYLAXIS

Student Name: _____ **may require treatment to prevent/treat anaphylaxis.**

SCHOOL (please check school of attendance):

☐	White River High School	Fax;	360-829-3351	☐	Glacier Middle School	Fax;	360-829-3391
☐	Elk Ridge Elementary	Fax;	360-829-3392	☐	Foothills Elementary	Fax;	360-829-3381
☐	Mountain Meadow Elementary	Fax;	360-829-3388	☐	Wilkeson Elementary	Fax;	360-829-3386

Student is allergic to: _____

The symptoms of anaphylaxis may include breathing difficulty, facial/throat swelling or tingling, hives, rash, itching, stomach cramps, nausea/vomiting, dizziness, or swelling away from the site of a bee sting.

This section to be filled out by Physician

The treatment plan for preventing/treating anaphylaxis at school is as follows: (check all that apply)
If student is exposed to allergen and/or exhibits any symptom of anaphylaxis,

Give epinephrine IMMEDIATELY:
☐ Epinephrine auto-injector 0.3 mg ☐ Epinephrine auto-injector 0.15 mg
☐ Repeat dose of epinephrine may be given if: _____

Call 911 at the time epinephrine is given and notify parent/guardian.
☐ This student also has asthma and may be at higher risk for developing anaphylaxis.

Student and parent/guardian have been instructed in use of epinephrine auto-injector: ☐ **Yes** ☐ **No**
Student may carry and self-administer the epinephrine auto-injector ordered above: ☐ **Yes** ☐ **No**

Health Care Provider's Signature	Telephone	FAX
Health Care Provider's Printed Name or Stamp	Date	

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY

Parent's Permission

I request that the school nurse, principal, or designated staff member be permitted to administer to my child, (Name of Child) _____ or allow my child to carry and self-administer as indicated above, the medication prescribed by (name of health care provider) _____ for the _____ school year.
The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

Parent/Guardian Signature	Home Phone	Work Phone
Date	Cell Phone	Other

Thank you for your assistance. Please return completed form to school nurse.

Student demonstrates skill level necessary to self-administer medication as ordered above.
School Nurse Signature: _____ Date: _____