Washoe County School District

Student Health Services

Fax: 775-353-5968

CONSENT AND REQUEST FOR ALLERGY/ANAPHYLAXIS MEDICATION

In order to receive assistance by WCSD personnel with medication administration, a student must have this completed form, including signatures, on file in the school health office. This applies to over-the-counter as well as prescription medication. A prescription label ***is not considered*** an order from a physician or authorized medical provider.

All prescription medication must be in a current pharmacy container labeled with the student's name, the name of the physician or authorized medical provider, expiration date, medication, dosage, and frequency. Non-prescription medication must be in the original packaging, labeled with the student's name and date of birth. The amount of medication that will be kept at school will be determined in cooperation with the school nurse, parent, and principal. **Any change in type, frequency or amount of medication will require a new form to be completed and signed by the physician/authorized medical provider and co-signed by the parent/guardian.** If a student requires assistance with more than one medication, a separate form must be completed for each medication.

Please return pages 1 & 2 of this form to the school's health office

School Year: _____

Student Name: _____ **Date of Birth**: _____**WCSD School**: _____

The above named student is allergic to _____ and, if exposed to the allergen, will require administration of medication, as described below:

Epinephrine Auto Injector PRN ☐ 0.15 mg. IM ☐ 0.30 mg IM

FOR ANY of the following symptoms of anaphylaxis:

Heart Fainting, pale, blue, sickly color

Lung Shortness of breath, repetitive coughing, wheezing

Throat Tightening of throat, hoarseness, hacking cough

Mouth Itching, tingling, or swelling of lips, tongue, mouth

Gut Sudden, severe nausea, abdominal cramps, vomiting, diarrhea, if suspected exposure to allergen above

Skin Swelling of the face or extremities or ***rapidly spreading*** hives/ itchy rash

Other _____

☐ **Repeat dose** in _____minutes ***if*** EMS has not arrived and symptoms continue

NOTE: SCHOOL PERSONNEL WILL CALL 911 FOR ANY SYMPTOMS REQUIRING ADMINISTRATION OF EPINEPHRINE

CONSENT AND REQUEST FOR ALLERGY/ANAPHYLAXIS MEDICATION **Page 2**

Student Name: _____ **Date of Birth**: _____

For ***MILD*** **allergic symptoms,** as noted below, with **NO known allergen exposure,** administer:

Medication_____ **Dose** _____ **Route**_____

Nose Itchy runny nose, sneezing

Mouth Itchy mouth without swelling

Skin A few hives with mild itching

Gut Mild nausea/discomfort

Other _____

Interval between doses _____ **Maximum doses per day** _____

The undersigned parent or guardian hereby requests the Washoe County School District to assist and supervise the above named student in taking the above described medication, as set forth, and consents to such assistance and supervision during the school day. The undersigned parent or guardian of the above student agrees to provide the above medication and to assume all responsibility for maintaining the supply of the medication and replacing such medication when its effectiveness has lapsed by reason of time.

In addition, the parent or guardian hereby gives permission to the school nurse at the above described school to exchange confidential information, relative to the medication noted above, with above-signed physician/authorized medical provider; and further hereby agrees to hold the Washoe County School District, the Board of Trustees of the District, and all agents of the District harmless from any liability for their participation in assisting and supervising the above named student in taking this medication.

Medications that are kept in the school health office may not be sent home with students. Medications not claimed or picked up by the parent/guardian or their designee by the day following the last day of the school year will be disposed of by the school nurse or designee.

Physician/Authorized Medical Provider Name (print) _____ Phone _____

Physician/Authorized Medical Provider Signature _____ Date _____

Parent/Guardian Name (print) _____ Phone _____

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

THIS CONSENT AND REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR