



OUR LADY OF GRACE  
MONTESSORI SCHOOL & CENTER

PARENT AND PRESCRIBER'S AUTHORIZATION FOR  
ADMINISTRATION FOR MEDICATION IN SCHOOL

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child \_\_\_\_\_ Grade \_\_\_\_\_ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication. Furthermore, I understand it is my responsibility to immediately notify the Health Office of any change in the type, dosage or frequency of administering the medication.

\*I give permission to share information on my child's Emergency Care Plan with staff on a need to know basis:

Signature (Parent or Guardian): \_\_\_\_\_

Address \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

I request that my patient, as listed below, receive the following medication:

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-9 \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Prescribed Dosage, Frequency and Route of Administration: \_\_\_\_\_

\_\_\_\_\_

Time to be taken during school hours: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

In the event of a field trip, can this dose be omitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Licensed Prescriber and Title (Please Print) \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Stamp:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following foods:** \_\_\_\_\_

**THEREFORE:**

- If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.
- If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:  
**SEVERE SYMPTOMS**



**LUNG**

Short of breath, wheezing, repetitive cough



**HEART**

Pale, blue, faint, weak pulse, dizzy



**THROAT**

Tight, hoarse, trouble breathing/ swallowing



**MOUTH**

Significant swelling of the tongue and/or lips



**SKIN**

Many hives over body, widespread redness



**GUT**

Repetitive vomiting, severe diarrhea



**OTHER**

Feeling something bad is about to happen, anxiety, confusion

**OR A COMBINATION** of symptoms from different body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

**MILD SYMPTOMS**



**NOSE**

Itchy/runny nose, sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives, mild itch



**GUT**

Mild nausea/ discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE