

Gaston County Schools

Physician's Order and Treatment Plan for Student with Anaphylaxis

(This form replaces the Authorization of Medication for Students in School. School nurse will complete separate health plan.)

STUDENT'S NAME: _____ BIRTHDATE: _____

DIAGNOSIS/KNOWN ALLERGEN: _____

PHYSICIAN MEDICATION ORDERS

MEDICATION/DOSAGE: _____

INDICATIONS/INSTRUCTIONS: _____

MEDICATION/DOSAGE: _____

INDICATIONS/INSTRUCTIONS: _____

Student understands and has been instructed in self-administration of the medication(s) for anaphylaxis . YES/NO

Student has demonstrated the skill level necessary to self-administer the medication(s) for anaphylaxis. YES/NO

If the questions above are answered yes and the student is able to self-administer his or her medication, the Gaston County Board of Education and its agents are not liable for injury from the student's possession and self administration.

EMERGENCY PLAN

CALL 911 IF EPINEPHRINE AUTO-INJECTOR IS ADMINISTERED OR FOR SIGNS OF SEVERE ANAPHYLAXIS.

COMMENTS: _____

I hereby give permission for my child to receive medication during school hours. I give consent for the school nurse to exchange information with the medication prescriber about medication administration, dose clarification, response to medication, adverse effects, etc. On behalf of my child, I absolve Gaston County Board of Education and their agent and employees from any and all liability whatsoever that may result from my child taking this prescribed medication. I agree to supply the medication as needed.

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|-------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------|
| Parent/Guardian Signature Date: Telephone #: | Health Care Provider Signature Date: Telephone #: | Printed Physician name or clinic stamp |
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Student has parental permission to self care and self administer medication. YES/NO _____

Parent Signature

School Nurse Signature _____ Date _____