FEDERAL WAY PUBLIC SCHOOLS
SEVERE ALLERGIC REACTION TREATMENT ORDERS

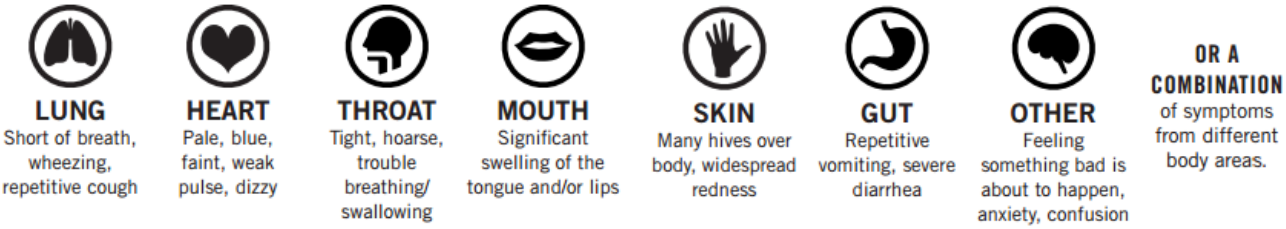
STUDENT NAME		DOB		ID NUMBER	
SCHOOL		GRADE		ACADEMIC YR	

TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER

Student is allergic to: _____

Student has asthma ❑ No ❑ Yes (at increased risk for developing anaphylaxis)

Symptoms of Anaphylaxis



Treatment Plan for preventing/treating anaphylaxis at schools is as follows: (*check all that apply*)

1. **Give epinephrine IMMEDIATELY** if student is exposed to allergen and/or exhibits any symptom of anaphylaxis.
   - ❑ Epinephrine auto-injector 0.3 mg
   - ❑ Epinephrine auto-injector 0.15 mg
   - ❑ Repeat dose of epinephrine may be given (if available) in 10-15 minutes if symptoms not relieved and EMS has not arrived.

2. **Call 911 at the time epinephrine is given and notify parent/guardian.**

3. After epinephrine is given, administer the following medication (antihistamine, albuterol, etc.) if available

   ❑ _____ (*Name of medication*) _____ (*Dose & route*) _____ (*Other instructions*)

   ❑ _____ (*Name of medication*) _____ (*Dose & route*) _____ (*Other instructions*)

Student and parent/guardian have been instructed in use of epinephrine auto-injector. ❑ Yes ❑ No

Student may carry and self-administer Epinephrine auto-injector, antihistamine, and/or albuterol inhaler. ❑ Yes ❑ No

Student may also use rescue inhaler for signs and symptoms of asthma unrelated to anaphylaxis. ❑ Yes ❑ No

Duration: ❑ Entire school year ❑ Specific date (*not to exceed current school year*): _____

Provider Signature		Provider Name		Date	
Clinic Name		Phone		Fax	

TO BE COMPLETED BY A PARENT/GUARDIAN

I request that medication be given to my student as ordered by the licensed health professional (LHP). I give Health Services staff permission to communicate with the LHP/medical staff about this medication and the condition for which it is prescribed. I understand that medication may be given by a school nurse or trained school staff. I release school staff from any liability in the administration of this medication at school. I agree to notify the school nurse if my student decides to participate in any district-sponsored activity outside of the normal school day (sports, clubs, etc.). I request and authorize my student to carry and/or self-administer this medication (❑ **Yes** ❑ **No**) with the understanding that permission to self-administer may be revoked by the principal/school nurse if it is determined that the student cannot safely and effectively self-administer.

Parent/Guardian Signature		Date	
School Nurse Signature		Date	