AUTHORIZATION OF EMERGENCY TREATMENT

Photo of Student

______________________ is allergic to: __________________________

STEP 1: ASSESS THE SITUATION

If you suspect that a food allergen has been ingested (or insect sting), immediately determine the symptoms and treat the reaction as follows.

Symptoms	Give Medication Checked "X"	
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	☐ Antihistamine	☐ EpiPen
Skin: Hives, swelling on face or extremities, itchy rash	☐ Antihistamine	☐ EpiPen
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐ Antihistamine	☐ EpiPen
Throat: Tightening of throat, hoarseness, hacking cough	☐ Antihistamine	☐ EpiPen
Lung: shortness of breath, repetitive coughing, wheezing	☐ Antihistamine	☐ EpiPen
Heart: thready pulse, passing out, fainting, pale, blueness	☐ Antihistamine	☐ EpiPen
General: Panic, sudden fatigue, chills, fear of impending doom	☐ Antihistamine	☐ EpiPen
If a food allergen has been ingested, but no symptoms:	☐ Antihistamine	☐ EpiPen
If a reaction is progressing (several of the above affected):	☐ Antihistamine	☐ EpiPen

STEP 2: ADMINISTER MEDICATION

Antihistamine (liquid diphenhydramine, Benadryl or cetirizine, Zyrtec)
Give ________ Teaspoon(s) or ________ cc (________mg) by mouth.

OR

Epinephrine
EpiPen ________________mg (prescribed EpiPen injected into upper outer thigh
Directions for use of EpiPen

1. Pull of grey cap
2. Place balck tip on upper outer thigh
3. Press hard into thigh until it clicks
4. Hold in place 10 seconds, remove and massage area.
5. Discard EpiPen in impermeable can and dispose or give to emergency care responder. (Do not return to holder or put in trash),

STEP 3: CALL 911

Then CALL 911 and state the child has had a severe reaction, and additional does of epinephrine doses may be needed.

STEP 4: CONTACT PARENTS/GUARDIANS

Name: ______________________________ Relationship: ________________
Phone 1: ____________________ Phone 2: __________________________

Name: ______________________________ Relationship: ________________
Phone 1: ____________________ Phone 2: __________________________

Other allergies, medication allergies, medical conditions, ________________ Approx. Weight: _______lbs.

______________________________ ______________________________

Physician's Signature **Date** **Parent Signature** **Date**

Licensed Authorized Prescribing Practitioner Authorization to Administer Medication in School
Reference: Policy # 2240

Child's Name ______________________ Birth Date ____________

Medication ______________________

Dosage ______________________

To be given at the following time(s) ______________________

____

____

Special Instructions ______________________

____

____

Purpose of Medication ______________________

____

____

Side effects that need to be reported ______________________

____

____

Starting Date ____________ Ending Date ____________

____
Signature of Licensed Authorized Prescribing Practitioner

Phone Number ______________________ Date ____________

If a child has a condition that might require medication on an emergency basis (e.g., in the case of a child's allergic reaction, asthma attack, etc.), the child's parent or legal guardian must provide all necessary information and training or instruction to the designated staff members who might be responsible for administering such medication or carrying out such medical procedures.

Authorization to Administer Medication
Reference: Policy # 2240

A new authorization form must be completed at the beginning of each school year and each time there is a change in dosage or time of administration.

Parents or guardians are requested to be present to administer any necessary medication to their children whenever possible. If a parent or guardian of the child is unable to be present to administer any necessary medication only a designated trained staff member may administer the medication. No medication, including aspirin, cough and cold medication, decongestants, or other over-the-counter or prescription medications shall be administered by any Registered Nurse (RN) or trained delegated school personnel except under the following conditions:

1. Written instructions from the child's Licensed Authorized Prescribing Practitioner (LAPP) must be provided, and must state the following:
   - ✓ The child's name
   - ✓ The name of the medication;
   - ✓ The proper dosage and route of the medication;
   - ✓ The purpose of the medication;
   - ✓ The time of day/circumstances in which the medication is to be administered;
   - ✓ The anticipated number of days the medication must administered; and
   - ✓ Any possible side effects of the medication.

2. Any medication must be brought in a container appropriately labeled by a pharmacy or the child's LAPP and must be picked up by an adult after the designated time period or it will be discarded. ***Please ask the pharmacist for a separate labeled medicine bottle to keep at school.***

_______________________________________ _______________________

Child's Name (Printed) *Date*

By signing this document I give permission for my child's LAPP to share information about the administration of this medication and the child's health care condition with the school staff designated to administer medication. I hereby authorize an RN any trained delegated school personnel to administer medication to my child according to the written instructions of the child's LAPP and certify that the above conditions have been met in their entirety.

I release the Archdiocese of Denver, RN and any trained delegated staff members from liability for any adverse reaction suffered by my child as a result of the administration of medication to my child in accordance with the written instruction of the child's LAPP. I agree to indemnify the Archdiocese of Denver and any trained delegated staff members for any medical expenses, legal expenses, or liability related to any adverse reaction suffered by my child as a result of the administration of (name of medication) ______________________________
________________ to my child in accordance with the written instruction of the child's LHCP.

I have carefully read this Authorization to Administer Medication, and I understand and agree to each of the covenants and conditions set for above. This Authorization to Administer Medication is effective for ______________________________ (state the relevant time period, such as one day or one week, up to one year for chronic conditions), unless earlier revoked.

______________________________ ______________________________

Parent or Guardian (Print Name) *Date*

____

Signature of Parent or Guardian

Home Phone ______________________________

Cell Phone ______________________________

Work Phone ______________________________

Consent, Medical Authorization, and Release
Reference: Administrator's Manual Policy # 2240

We consent for our child, ______________________________
(hereinafter referred to as "our child") to participate and attend ______________________
______________________________ ("school") and in any activity or trip sponsored by the school of the Archdiocese of Denver or any of its affiliated agencies. In exchange for the participation of our child in such activities, we agree to the following.

We authorize the Designated Supervisor(s) to authorize and consent to any medical care for our child that he or she reasonably believes necessary, including, but not limited to, hospitalization or surgery. We agree to pay any expenses related to such medical care. We understand and acknowledge that the Designated Supervisor(s) will attempt to obtain our permission by telephone before authorizing or consenting to any medical care for our child if time and conditions permit.

We understand and acknowledge that any medical expenses related to illness or injury to our child are not covered by any insurance program maintained by the Archdiocese of Denver, and that we are responsible for such expenses.

We, individually, and in our capacities as parent and guardians acting on our own behalf and on behalf of our child, release the Archdiocese of Denver, and all of its affiliated agencies, schools, and their respective priests, religious men and women, deacons, teachers, principals, agents, employees, and volunteers, from all demands, claims, or liability, in low or in equity, which has arisen or may arise, for any damage, loss, illness or injury to our child, including but not limited to claims arising out of allergic reactions, and waive any such demands, claims, or liability.

We further agree to indemnify and hold harmless the Archdiocese of Denver, as well as, any of its affiliated agencies and their respective agents, directors, officers, employees, and volunteers, from any and all claims demands made against any of them for any damage, loss, illness or injury to our child.

______________________ ______________________________
Date *Signature, Mother of*

____
Child's Name

______________________ ______________________________
Date *Signature, Father of*

____
Child's Name