Life-Threatening Allergies Medication Permission Form
Western Academy School Year 2023-2024

Student Name:_____D.O.B._____ Grade_____

ALLERGIC TO: _____ Asthmatic: _____Yes* _____ No
*High risk for severe reaction

THIS CHILD'S SIGNS OF AN ALLERGIC REACTION MAY INCLUDE (please check all that apply):

Systems	Symptoms
___*MOUTH	Itching & swelling of the lips, tongue, or mouth
___ THROAT	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
___ SKIN	Hives, itchy rash, and/or swelling about the face or extremities
___ GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea
___*LUNG	Shortness of breath, repetitive coughing, and/or wheezing
___*HEART	"Thread" pulse, "passing-out"

*** The severity of symptoms can quickly change**
*** All above symptoms can potentially progress to a life-threatening situation**

Action for MINOR Reaction

If symptom(s) are only: _____ Give (medication/dose/route):_____

_____.

Then call:

1. Mother at_____, or Father at_____, or emergency contacts.
2. Dr. _____ at_____

- This child may/ may not carry this medication. (Circle where the child is able to carry medication: school, sports events, camps, out of school activities).
- If condition does not improve within 10 or _____minutes follow the steps for "Action for Major Reaction" below:

Action for MAJOR Reaction- DO NOT HESITATE TO CALL 911!

If ingestion is suspected and/or symptom(s) are: _____

Give (Medications/dose/route): _____

_____IMMEDIATELY!

THEN call: 911 (ask for advanced life support)

1. Mother _____, Father _____, or emergency contacts.
2. Dr. _____at _____.

This child may/may not carry this medication. Circle where the child is able to carry medication: school, sports events, camps, field trips.

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

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EMERGENCY CONTACTS

1. _____
   Name Phone

   _____
   Relation to student

2. _____
   Name Phone

   _____
   Relation to student

3. _____
   Name Phone

   _____
   Relation to student

EPIPEN® and EPIPEN®JR. DIRECTIONS

1. Pull off gray safety cap

2. Place black tip on outer thigh (always apply to thigh)

3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to three. The ®EpiPen unit should then be removed and discarded. Massage the injection area for three seconds.

_____ has severe allergies to _____.
(Student's Name)

This allergy may cause _____ in my child.

- I have provided to the school the physician's medication permission and instructions. I want these instructions carried out.
- I have instructed my child about his/her allergy, how to avoid exposure to the allergen, care to take if exposure occurs.
- I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication.

I hereby request that the medication specified above be given to the above-named student and that someone may give the medication other than a medically trained person. I know 911 will be called with the use of epinephrine.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless Western Academy, its servants, agents, employees, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against Western Academy, its agents, servants, or employees, including the individual giving or failing to give the medication.

Parent Signature _____ Date_____

This "Emergency and "Allergy Medication Permission Form" may be given to appropriate Teachers, Substitute teachers and Staff.