Washoe County School District

Student Health Services

Student ID: _____

CONSENT AND REQUEST FOR ALLERGY/ANAPHYLAXIS MEDICATION

In order to receive assistance from WCSD personnel with medication administration, a student should have this completed form, including signatures, on file in the school health office.

All prescription medication must be in a current pharmacy container labeled with the student's name, the name of the physician or authorized medical provider, expiration date, medication, dosage, and frequency. The amount of medication that will be kept at school will be determined in cooperation with the school nurse, parent, and principal. **Any change in type, frequency or amount of medication will require a new form to be completed and signed by the physician/authorized medical provider and co-signed by the parent/guardian.** If a student requires assistance with more than one medication, a separate form must be completed for each medication.

School Year: _____ **WCSD School**: _____

Student Name: _____ **Date of Birth**: _____

The above-named student is allergic to _____ and, if exposed to the allergen, will require administration of medication, as described below:

Epinephrine Auto Injector PRN ☐ 0.15 mg. IM ☐ 0.30 mg IM

FOR ANY of the following symptoms of anaphylaxis:
Heart Fainting, pale, blue, sickly color
Lung Shortness of breath, repetitive coughing, wheezing
Throat Tightening of throat, hoarseness, hacking cough
Mouth Itching, tingling, or swelling of lips, tongue, mouth
Gut Sudden, severe nausea, abdominal cramps, vomiting, diarrhea, if suspected exposure to allergen above
Skin Swelling of the face or extremities or ***rapidly spreading*** hives/ itchy rash

Other symptoms as specified: _____

☐ **Repeat dose** in _____minutes ***if*** EMS has not arrived and symptoms continue.

SCHOOL PERSONNEL WILL CALL 911 FOR ANY SYMPTOMS REQUIRING ADMINISTRATION OF EPINEPHRINE

The undersigned parent or guardian hereby requests the Washoe County School District to assist and supervise the above-named student in taking the above-described medication, as set forth, and consents to such assistance and supervision during the school day. The undersigned parent or guardian of the above student agrees to provide the above medication and to assume all responsibility for maintaining the supply of the medication and replacing such medication when it has expired.

In addition, the parent or guardian hereby gives permission to the school nurse at the above described school to exchange confidential information relative to the medication noted above with physician/authorized medical provider below; and further hereby agrees to hold the Washoe County School District, the Board of Trustees of the District, and all agents of the District harmless from any liability for their participation in assisting and supervising the above named student in taking this medication.

Physician/Authorized Medical Provider Name (print) _____ Phone _____

Physician/Authorized Medical Provider Signature _____ Date _____

Parent/Guardian Name (print) _____ Phone _____

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

THIS CONSENT AND REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR