FRANKLIN SQUARE SCHOOL DISTRICT
FRANKLIN SQUARE, NEW YORK

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled container from the pharmacy.

By permitting the administering of prescribed medicines to my child as outlined below, I, for myself and my child, expressly release the Franklin Square School District and its personnel of any liability which might arise from such administering the prescribed medicine to my child.

I expressly waive any right of action against the Franklin Square School District, or its personnel, arising out of any injury, damage, hurt or impairment, of either a physical or mental nature which might result directly or indirectly from the administering of such prescription medicines to my child by the Franklin Square School District.

I understand that if the Registered School Nurse is absent and no substitute nurse is available, I will be notified in the morning. Designated trained school personnel may assist my child with the Epi-Pen administration if it is deemed necessary.

Parent/Guardian signature: _____ Date_____

Address: _____

Phone: Home _____ Work _____

B. To be completed by the licensed health care prescriber:
I request that my patient, as listed below, receive the following medication:

Student: _____ D.O.B. _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

_____

Time to be taken during school hours: _____

Duration of Treatment: _____

Possible side effects and adverse reactions, if any: _____

Other Recommendations: _____

_____
Licensed Prescriber's name, title, Signature *Date*

_____
Address *Phone*

FRANKLIN SQUARE UFSD
Food Allergy Emergency Care Plan

Place Child's Picture Here

Student's Name: _____ **D.O.B:** _____ **Teacher:** _____

Allergy to: _____ **Asthmatic:** Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT

☐ Rinse contact area with water, if appropriate

Symptoms:	**Give Checked Medication:**** **(To be determined by physician authorizing treatment)
▪ If a food allergen has been ingested, but *no symptoms*	☐ Epinephrine ☐ Antihistamine
▪ **Mouth:** Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ **Skin:** Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ **Gut:** Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ ***Throat:** tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ ***Lung:** Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ ***Heart:** Weak or thread pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ *Other _____	☐ Epinephrine ☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine
*Potentially life-threatening. The severity of symptoms can quickly change.	

DOSAGE

Epinephrine: inject intramuscularly (circle one)

EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg Adrenaclick™ 0.3 mg
Adrenaclick™ 0.15 mg Auvi-Q™ .15 mg Auvi-Q™ .3 mg

Antihistamine: give (medication/dose/route) _____

Other: give (medication/dose/route) _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent _____ Phone Number(s): _____
4. Emergency contacts:
   a. Name/Relationship _____ Phone Number: _____
   b. Name/Relationship _____ Phone Number: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)