Iredell-Statesville Schools
Severe Allergy Physician/Parent Form

Student's Name: _____ **DOB: _____**

Teacher/Grade_____ **Bus # _____**

Allergy to: _____

Please circle type of exposure that has caused a reaction:
Ingestion (eat)
Inhalation (smell)
Contact (touch)

Asthmatic: **Yes*□** **No □** ***Higher risk for severe reaction**

►Step 1: Treatment◄

Symptoms:	**Give Checked Medication** **(To be determined by physician)	
• 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 pulse, low B/P, fainting, pale, blueness)	□Epinephrine	□Antihistamine
• **Other ‡** _____	□Epinephrine	□Antihistamine
• **If reaction is progressing (several areas affected), give:‡**	□Epinephrine	□Antihistamine
• **Can Epinephrine be given after antihistamine:**	□Yes	□No
How long should you wait:_____		

‡ - Indicates Life-Threatening Response

Please complete both sides of the form

Dosage:

Epinephrine: (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3mg Twinject® 0.15mg

Antihistamine: give_____

Medication/dose/route

Other: give_____

Medication/dose/route

☐Yes ☐No The student has been instructed in self-administration of Epi-Pen. The student understands and has demonstrated the skill level necessary to self-administer the Epi-Pen. I request the student be allowed to carry their Epi-Pen and self-medicate according to my instructions as written above.

Physician's Signature _____ Date_____

Physician's Name and Clinic Name _____

Parent Section

►Step 2: Emergency Calls◄

1. **Call 911**
2. **Parent** _____ Phone Number(s)_____
3. **Other Emergency Contacts:**
   - _____ Phone Number(s)_____
   - _____ Phone Number(s)_____

Request for Self-Medication

I request that my child be allowed to carry his/her Epi-Pen and self-administer this medication as directed by his/her physician. I agree that my child is knowledgeable of his/her own treatment and is capable of self-administering the prescribed medication. As required by North Carolina Law GS 115c-375.2; I will provide to the school a back-up Epi-Pen to be kept at school for immediate access by my child or staff in the event of an anaphylactic reaction and inability to locate my child's Epi-Pen. On behalf of my child, I release the Iredell-Statesville Board of Education and their agents and employees from any liability whatsoever that may result from my child taking this prescribed medication.

Date_____ Parent Signature _____

The following is to be signed by the student and **witnessed by school staff:** I feel knowledgeable and competent to take my medication as prescribed. I will not, at any time, share my medication with others and I will keep it secure from other students.

Date _____ Student Signature _____ Witness_____

I understand it is my responsibility to furnish the medication in the appropriate container to the school, and to provide a physician's signature. I give permission for the school nurse to communicate with my child's physician regarding the above allergy/medication if necessary.

Parent signature______________________________ **Date** _________________________