



Authorization for Treatment of Children with Life-threatening Allergies

If treatment includes the administration of epinephrine or any other prescription medication, this form must be completed and signed by the child's physician.

Child's Name _____ Child's Birth Date _____

Allergens: Provide a list of all substances and/or events that may trigger an allergic reaction in this child.

Step 1 . . . Treatment

Symptoms: Check boxes next to symptoms that may occur

- If a food allergen has been ingested, but no symptoms:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat Tightening of throat, hoarseness, hacking cough
- Lungs Shortness of breath, repetitive coughing, wheezing
- Heart Weak or thready pulse, low blood pressure, fainting, pale
- Other _____
- If reaction is progressing, several of the above areas affected:

*Give Checked Medication

To be determined by physician authorizing treatment.

- Epinephrine Antihistamine
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Do not hesitate to medicate or transport a child to a medical facility even if parent/guardian cannot be reached.

Dosage:

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

Antihistamine: Medication/dose/route _____

Other: Medication/dose/route _____

Step 2 . . . Call 911 State that an allergic reaction has been treated.

Then call:

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

#1 Emergency Contact: _____ Phone: _____

#2 Emergency Contact: _____ Phone: _____

Child's Physician

Name: _____ Phone: _____

Address: _____ Alt. Phone: _____

Physician Signature _____ Date: _____

Parent/Guardian Authorization

By signing this form, I authorize the Oswegoland Park District to follow the instructions as stated above in this Authorization Form. I agree to update this form if my child's needs change.

Signature _____ Date _____