# TORRANCE UNIFIED SCHOOL DISTRICT
# PHYSICIAN'S AUTHORIZATION for MANAGEMENT OF ANAPHYLAXIS AND EPINEPHRINE AUTO-INJECTOR ADMINISTRATION AT SCHOOL

**School**_____**Health Office (310)**_____**Fax (310)972-**_____

**TO BE COMPLETED BY PARENT:**

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| **Last Name of Student, First Name** | **Grade** | **Sex** | **Date of Birth** | **School** |

**For Students in Grades K-5** _____ _____
**Teacher** **Room**

**TO BE COMPLETED BY AN AUTHORIZED HEALTH CARE PROVIDER*:**

1. Allergens or factors causing anaphylactic reaction: _____
2. Student's most commons signs and symptoms: _____
3. Student's typical reaction time after allergen exposure: _____
4. Date of last anaphylactic reaction: _____
5. Medication to be given before EpiPen? ☐ Yes ☐ No If yes, name of medication: _____
6. Medication to be given after EpiPen? ☐ Yes ☐ No If yes, name of medication: _____

**MEDICATION ORDERS (TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER*)**

| Name of Medication | Dosage | Route/Frequency | Indications or Symptoms (please be specific) |
|---|---|---|---|
| **Antihistamine:**<br>☐ Benadryl (Diphenhydramine)<br>☐ Zyrtec (Cetirizine)<br>☐ Other: _____ | _____ml liquid (12.5mg/5ml)<br>_____ 12.5 mg chewable tablet(s)<br>_____ 25mg tablet/capsule(s)<br>Other: _____ | Route: PO<br>Frequency:<br>_____ | _____<br>_____ |
| **Epinephrine Auto-injector:**<br>☐ EpiPen<br>☐ Auvi-Q<br>☐ _____ | ☐ 0.15 mg<br>☐ 0.30 mg<br>☐ _____ | ☐ IM in outer mid-thigh<br>☐ Other:<br>_____ | **Administer Epinephrine when:**<br>☐ Student has severe symptoms of anaphylaxis<br>☐ Student has **definite** exposure to allergen<br>☐ Student has **any** symptoms after suspected exposure to allergen<br>☐ **Administer 2nd dose _____ minutes after 1st dose if symptoms persist or recur** |

**TO BE COMPLETED BY SCHOOL STAFF UPON RECIEPT OF MEDICATION:**

- Medication received matches physician's order (name, dose form, dosage, unopened for OTC) _____
- Medication(s) and quantity received _____

_____ _____
Parent/Guardian Signature Date Staff Signature Date

**TO BE COMPLETED BY SCHOOL STAFF UPON RETURN OF UNUSED MEDICATION:**

- Medication(s) and quantity returned: _____

_____ _____
Parent/Guardian Signature Date Staff Signature Date