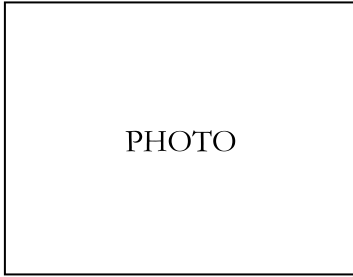
SOLOMON SCHECHTER
SCHOOL OF WESTCHESTER



Authorization of Emergency Treatment for Child with Severe Allergies

This form is specific to students with severe food and other allergies. It is to be completed annually by your physician in addition to the school physical exam forms and the permission for medication form.

_________________________________ is allergic to: _________________________________
(Name of student/ Date of birth)

Has this child been taken to an emergency room for allergy management? Y / N If yes, please explain and give date(s):
____

STEP 1: TREATMENT
If you suspect that an allergen has been taken then immediately determine the symptoms and treat the reaction as follows:

A) Symptoms:		**Give Medication marked "X"**
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	| | Benadryl | | EpiPen
Skin	Hives, swelling on face or extremities, itchy rash	| | Benadryl | | EpiPen
Abdomen	Nausea, abdominal cramps, vomiting, diarrhea	| | Benadryl | | EpiPen
Throat	Tightening of throat, hoarseness, hacking cough	| | Benadryl | | EpiPen
Lung	Shortness of breath, repetitive coughing, wheezing,	| | Benadryl | | EpiPen
Heart	Thready pulse, passing out, fainting, paleness, blueness	| | Benadryl | | EpiPen
General	Panic, sudden fatigue, chills, fear of impending doom	| | Benadryl | | EpiPen
If a food allergen has been ingested, but *no symptoms are present*		|x| Benadryl | | EpiPen | | Other
If a reaction is progressing (several of the above areas affected):		|x| Benadryl |x| **EpiPen**

B) Medication Doses:
Antihistamine (liquid diphenhydramine, Benadryl™):
Give _________________ Teaspoon(s), _______cc (________mg) by mouth.
Epinephrine:
EpiPen™ [Epi-Pen_______ (________mg)] injected once into upper outer thigh
Epinephrine injection may need to be repeated if the child's symptoms persist or get worse.

STEP 2: CALLS ** Call 911 **
NEAREST HOSPITAL:____
State that the child had a severe allergic reaction and additional epinephrine doses may be needed.
Contact information:
Name of parent:____
Phone (1) ___________________________ Phone (2) ___________________________
Name of parent:____
Phone (1) ___________________________ Phone (2) ___________________________
Other allergies, medication allergies, medical conditions: _________ Approximate weight: _________ lbs

DO NOT HESITATE TO ADMINISTER MEDICATION OR TAKE THE CHILD TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED!

Name of allergist _________________________________ Phone ______________________
Name of pediatrician ______________________________ Phone______________________

____
Signature of physician Date Signature of parent Date