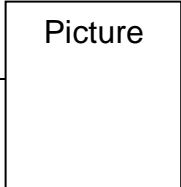


Student Name _____ DOB _____
 Parent/Guardian _____ Phone _____
 Emergency Contact _____ Phone _____
 Treating Physician _____ Phone _____



Allergy to: _____ Dx of Asthma? Yes No

Severity Classification

- Mild Intermittent
- Mild Persistent
- Moderate Persistent
- Severe Persistent

Triggers

- Peanuts
- Tree nuts
- Shellfish
- Latex
- eggs
- milk
- medication
- animals
- Insect Stings (list) _____
- All dairy
- fish
- other _____

School Nutrition Modification Evaluation Form Must Be Completed by Prescribing Physician For ALL Dietary Modifications

Mild to Moderate Allergic Reaction

- minor swelling of lips, face, eyes
- hives or welts
- abdominal pain
- vomiting

Action: Stay with child and call for help from health unit; give medication (if prescribed); & immediately contact parent/guardian

Medication: MD-Please Specify

Antihistamine: _____

Anaphylaxis—Severe Reaction or No Improvement

- difficulty/noisy breathing
- swelling of tongue
- cold, clammy, sweaty skin
- swelling/tightness in throat
- pale and floppy (young children)
- flushed face
- difficulty talking and/or horse voice
- loss of consciousness



Administer Medication & Call 911

Epinephrine _____
 (via auto injector unless otherwise specified)

Location of medication: Health Unit Emergency Action Medication must be with student at all times, *either on their person or with an accompanying adult*

Administration of medication: School Nurse or trained unlicensed school personnel Self administration with adult supervision

Independent Self Administration—it is my professional opinion that this student is able to carry above prescribed medication with them at all times—during the school day, on field trips, and while participating in before or after school clubs/events/athletics. He/she has been instructed on the indication for medication usage and the method of administration.

Please Note: The school nurse does not always attend field trips or after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication. Student authorized for independent self administration of medication are not monitored by school staff, however school staff are available for emergency response during all school sponsored activities.

Prescription medication or treatment daily at school / at home for this condition: _____

During a field trip, scheduled daily medication: requires a trained staff member to administer medication
 is authorized to carry and self administer medication

X _____
 Physician or Authorized Healthcare Provider Signature Telephone Number Date Signed

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other staff members that have direct contact with my child for the current school year. I understand that a trained school staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self-administered is not monitored by staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school health unit shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I understand that the Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read.

I hereby agree to release and hold staff members free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____
 Parent/Guardian Signature Date Signed