MOLALLA RIVER

AUTHORIZATION FOR HEALTHCARE PROCEDURES: Allergies, Asthma & Anaphylaxis

Student Name:		DOB	

As the parent of the above identified student, I request that my child receive the following health services as per written nursing protocol, and MD orders as it relates to my student's emergency management in the school setting for the diagnosis and specialized care of:

Diagnosis	Procedure
☐ Asthma	☐ Response to Asthma
☐ Anaphylaxis	☐ Response to Anaphylaxis including administration of epinephrine
☐ Allergies	☐ Response to Allergies
☐ Other:	☐ Potential Complication:

As the parent or guardian of the above referenced student, I authorize the administration of epinephrine for severe allergic reaction per MD order and nursing protocol.

I understand that:

- Administration of epinephrine is done only by designated persons who have completed the Severe Allergic Reaction training as per ORS 433.8433.800-830 and received specific training from a Registered Nurse as per OAR 851-047-0040.
- The prescription label must read **"Administer immediately upon signs of anaphylaxis" or " Administer immediately upon exposure to allergen"** or written orders must be provided by an **Oregon** licensed physician.
- By signing this form I authorize the exchange of information between the district nurse, school personnel and my child's health care provider for the purposes of allergy management in the school setting.
- For the purposes of anaphylaxis management a physician's order is required for antihistamines.
- This authorization is valid for one year beyond the signed date.
- I will notify the school immediately if the health status changes, if there is a change of physicians, changes to physician's orders, and/or change or cancellation of health care.
- I am responsible to bring all necessary supplies and medications to school for my student and any medications not picked up by the last day of school will be disposed of.

Parents Signature Date