OSWEGOLAND PARK DISTRICT

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.

_____

_____

How the allergy is triggered? Airborne____ Touch____ Ingestion_____
Life-threatening_____ Non-life-threatening_____

Step 1 . . . Treatment

Symptoms: Check boxes next to symptoms that may occur		***Give Checked Medication** To be determined by physician authorizing treatment.
❒ If a food allergen has been ingested, but no symptoms:		❒ Epinephrine ❒ Antihistamine
❒ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	❒ Epinephrine ❒ Antihistamine
❒ Skin	Hives, itchy rash, swelling of the face or extremities	❒ Epinephrine ❒ Antihistamine
❒ Gut	Nausea, abdominal cramps, vomiting, diarrhea	❒ Epinephrine ❒ Antihistamine
❒ Throat	Tightening of throat, hoarseness, hacking cough	❒ Epinephrine ❒ Antihistamine
❒ Lungs	Shortness of breath, repetitive coughing, wheezing	❒ Epinephrine ❒ Antihistamine
❒ Heart	Weak or thready pulse, low blood pressure, fainting, pale	❒ Epinephrine ❒ Antihistamine
❒ Other	_____	❒ Epinephrine ❒ Antihistamine
❒ If reaction is progressing, several of the above areas affected:		❒ Epinephrine ❒ Antihistamine

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 _____

Child's Physician:

Name: _____ Phone: _____

Address: _____ Alt. Phone: _____

Physician Signature_____ Date: _____

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: _____

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 _____