POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
MEDICATION CONSENT/ALLERGY ACTION PLAN

Student:_______________________________ **D.O.B.** __________ **Teacher:** ____________________
Allergy to: ____

Diagnosed with asthma? ☐ No ☐ Yes (higher risk for severe reaction)

PHYSICIAN PLEASE COMPLETE THIS SECTION

CA Ed. Code Section 49423 & 49423.1 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school, to maintain or improve health status and to improve the potential for education and learning. Unless otherwise stated this order expires on the last instructional day of the school year or extended school year, e.g. summer school.

Symptoms: Please mark symptoms to be treated		**Give Checked Medication**	
☐ If a food allergen has been ingested, but no symptoms:		___ EpiPen	___ Antihistamine
☐ Mouth	Itching, tingling or swelling of lips, tongue, mouth	___ EpiPen	___ Antihistamine
☐ Skin	Hives, itchy rash, swelling of face or extremities	___ EpiPen	___ Antihistamine
☐ Gut	Nausea, abdominal cramps, vomiting, diarrhea	___ EpiPen	___ Antihistamine
☐ Throat	Tightening of throat, hoarseness, hacking cough	___ EpiPen	___ Antihistamine
☐ Lung	Shortness of breath, repetitive coughing, wheezing	___ EpiPen	___ Antihistamine
☐ Heart	Thready pulse, low blood pressure, fainting, pale blueness	___ EpiPen	___ Antihistamine
☐ Other	________________________________	___EpiPen	___Antihistamine

CALL 911! The severity of symptoms can quickly change to potentially life-threatening. State that an allergic reaction has been treated and more epinephrine may be needed.

MEDICATIONS TO BE GIVEN

Epinephrine: Inject intramuscularly **Dose:** ____

Antihistamine: ____
Medication/dose/route/frequency

Other: ____
Medication/dose/route/frequency

Medication administered until: ____

Physician's Signature:_____________________________ Date: ____________ NPI#: __________

Print Physician's name:_____________________________ Phone: ______________________

PARENT PLEASE COMPLETE THIS SECTION

I authorize school personnel to administer the above medication to my child as ordered by our physician. I give permission for the school nurse to communicate directly with our physician as necessary regarding any concerns or questions related to the administration of this medication

Parent/Guardian Signature:_________________________________ Date: ____________________

Home Phone: ______________________ Other Phone #s: ________________________________

Revised 7/18