BERLIN AREA SCHOOL DISTRICT
295 E. Marquette St., Berlin, WI 54923
Phone: 920-361-2442 ext. 3003 Fax 920-361-4352

Severe Allergy Reaction Medication Authorization Form

Including reactions to bee sting/insect bite allergies, food allergies, and/or other allergies

Student's Name: _____ D.O.B: _____ Grade: _____

School Year: _____ School (circle one): Clay Lamberton Elementary Berlin Middle Berlin High

To the Health Care Provider—please complete the following:

This student has a severe allergy to: _____.
If this student has been exposed to this allergen, please refer to the following protocol:

- **_____If has complaints of ill feelings or has a history of allergic reaction, give Benadryl (diphenhydramine) as ordered below:**

Dose of Diphenhydramine (Benadryl)
or write preferred antihistamine (*check preferred dose*):**

_____12.5 mg (one teaspoon liquid or chewable *{or fast melt}* equivalent)
_____25 mg (one adult capsule or two teaspoons liquid or two chewable equivalent)
_____37.5 mg (three teaspoons liquid or three chewable equivalent)
_____50 mg (two adult capsules or four teaspoons liquid or chewable equivalent)

- **_____Give this antihistamine instead *(name, dose)*:_____**

- **_____If the student worsens and has a rash, difficulty breathing, sweating, complaints of dizziness, a fast pulse, swelling of face and/or neck, and/or difficulty with speech, give Epinephrine (see below) and call 911. Also, notify the parents, school principal, and school nurse.**

Epinephrine[1] dose (*check dose and if may be repeated*):

- **_____ 0.15 mg Epinephrine Junior (weight 66 # or less)**
- **_____ 0.30 mg Epinephrine Adult (weight more than 66#)**
- **_____Repeat Epinephrine _____mg in _____ minutes if symptoms persist and ambulance has not yet arrived**.

[1]*Parents/guardians must provide the Epinephrine with a correct pharmaceutical label with student's name, prescriber name, dose, route, and instructions. They should also provide selected antihistamine.*

Physician Signature: _____ Date: _____

Address: _____ Phone: _____

~Parent signature gives BASD representative permission to follow both the above instructions and to communicate with the student's health care provider about the student's allergy status in the event of any concerns and/or questions with treatment and reaction.

Parent Signature: _____ Date: _____ *Reviewed 03/26/15 tm*