Berlin Area School District
Severe Allergy Reaction Medication Authorization Form

(Includes reactions to bee sting/insect bite allergies, food allergies and/or other allergies)

Today's Learners. Tomorrow's Leaders.

STUDENT INFORMATION		
Student Name	**Date of Birth**	**Grade**

District School Name			**School Year**
☐ Clay Lamberton Elementary Fax: (920) 361-4352	☐ Berlin Middle School Fax: (920) 361-3379	☐ Berlin High School Fax: 920-361-2005	

HEALTH CARE PROVIDER

This student has a severe allergy to:

If this student has been exposed to this allergen, please refer to the following protocol:

☐ If the student complains of ill feelings or has a history of allergic reaction, give Benadryl (diphenhydramine) as ordered below:

Dose of Diphenhydramine (Benadryl)		
☐	12.5 mg	(one teaspoon liquid, 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)

OR

☐ Give this antihistamine instead (name, dose):

Dose _____ Medicine Name _____

AND/OR

☐ If the student worsens and/or 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, principal & school nurse.

Epinephrine[1] dose (check dose and if may be repeated):		
☐	0.15 mg	Epinephrine Junior (weight is 66 lbs. or less)
☐	0.30 mg	Epinephrine Adult (weight is more than 66 lbs.)
☐	____ mg	Repeat Epinephrine in _____ minutes if symptoms persist and ambulance has not arrived yet.

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

Physician Signature	**Date**

PARENT/GUARDIAN

My signature below gives a BASD representative permission to follow both the instructions on this form 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/Guardian Name (please print)	**Relationship to Student**

Parent/Guardian Signature	**Date**

SCHOOL STAFF

Principal or District Nurse Signature	**Date**

Revised 06.13.23