**Primary Care Provider Authorization: Epipen**

Student Name_____ Date of Birth_____

First Presbyterian Preschool, Upland School Year_____

**Allergy To:**_____

**Asthma:** ___ Yes ___No

**Signs of an allergic reaction include:**

| Systems: | Symptoms: |
|---|---|
| Mouth | itching and swelling of the lips, tongue, or mouth |
| Throat* | itching and/or a sense of tightness in the throat, hoarseness, hacking cough |
| Skin | hives, itchy rash, and/or swelling about the face or extremities |
| Stomach | nausea, abdominal cramps, vomiting, and/or diarrhea |
| Lung* | shortness of breath, repetitive coughing, and/or wheezing |
| Heart* | "passing out" |

***The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!**

**EpiPen will be kept in classroom with teacher.**

**Emergency action for an allergic reaction:**

1. Administer emergency medication*

   Medication_____

   Dose_____

   Route:_____

2. Call EMS (911) - Preschool Cell Phone number is: 11 send
3. Call Parent/guardian or emergency contacts immediately:

Mother Name_____ Cell_____Home_____

Father Name_____Cell_____Work_____

4. Call Primary Care Provider(name)_____(phone)_____

***Do not hesitate to administer medication or call for emergency assistance**

_____ _____
Printed Name of MD Address

_____ _____ _____
Signature of MD Date Telephone Number of MD

**Note to parent guardian: Signing this form shall release First Presbyterian Preschool and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.

_____ _____ _____
Signature of Parent/Guardian Telephone No. Date

**Primary Care Provider Authorization: Epipen**

Student Name:_____ Date of Birth:_____

First Presbyterian Preschool School Year_____

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Primary Care Provider's Statement of Need

As primary care provider of the above-name student, I do herby acknowledge the necessity of specific emergency health procedures of this patient in the event he/she experiences the following heath concern during the school day: (Identify health concern/diagnosis).

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This patient's condition is such a serious nature that there would not be sufficient time to remove him/her from school premises or to await the arrival of medical help. Therefore, prompt treatment should be given by school personnel who have been instructed in the use of: (Specify emergency procedure and/or device required).

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Printed Name of MD Address

Signature of MD Date Telephone No.

Parent/Legal Guardian's Authorization and Consent

I am fully aware and have been informed by the above named primary care provider that my child's condition is of such a serious nature that, if it occurs, there would not be sufficient time to remove him/her from the school premises or to await the arrival of medical help, I hereby give my authorization and consent to school personnel to give prompt treatment, as specified above to my child.

*Note to parent/guardian: Signing this form shall release First Presbyterian Preschool and staff from liability of any nature that might result from this plan of action.

Signature of Parent/Guardian Date Telephone Number

Emergency Contact Telephone Relationship