

SEVERE ALLERGY MEDICATION FORM

I. To Be Completed by Licensed Physician

Child's Last Name

Child's First Name

Allergens:

____ Insect Bite/Sting (identify)

____ Animal Fur (identify)

____ Food Allergy (identify)

____ Other (identify)

Symptoms:

____ Shortness of breath or difficulty in breathing

____ Hives

____ Swelling of the face or lips

____ Vomiting

____ Other (explain)

____ Diarrhea

____ *Do not administer medication in the absence of known exposure to allergen.*

Procedures:

Please indicate all steps necessary and the order in which they should be taken.

___ Administer Medication (specify)

___ Call the area's emergency medical personnel (e.g. 911)

___ Call parent(s)/guardian(s) and child's physician

___ Other

Explain

Name of Medication(s)

Diagnosis/purpose of medication(s)

Dosage and form (tablet, liquid, etc.) prescribed

Time schedule

Date of Prescription(s)

Precise method of administering the medication

Length of time medication will be necessary

Possible side effects

Action to be taken in case of side effects

Storage instructions

Special instructions

I verify that this student is under my care and requires this medication.

Physician's Printed Name

Physician's Signature

Date

Phone Number

Street Address

City

State

Zip Code

**PART II
TO BE COMPLETED BY PARENT(S)/GUARDIAN(S)**

Student's First Name

Student's Last Name

The above named student is required to take medication prescribed by a licensed physician during school. I request that the designated Beacon Hill Classical Academy personnel administer the specified medication to my child in accordance with the instructions provided by the physician.

By signing this form, I/we authorize Beacon Hill Classical Academy to follow the above instructions in the Authorization Form. I/we agree to update this form every semester or sooner if my/our child's needs change.

Parent/Guardian Name

Parent/Guardian Name

Parent/Guardian Signature

Parent/Guardian Signature

Date

Date

**RELEASE AND WAIVER OF LIABILITY FOR ADMINISTERING EMERGENCY TREATMENT
TO CHILDREN WITH SEVERE ALLERGIES**

I/we _____ Parent(s)/Guardian(s) hereby on this

_____ day of _____, 2011, release Beacon Hill Classical

Academy and all their employees from any and all liability arising in law or equity as a

result of Beacon Hill Classical Academy employee administering emergency treatment

related to a severe allergic reaction, providing that Beacon Hill Classical Academy has used

reasonable care in providing care in accordance with the procedures outlined in the

Authorization Form.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date