

TREATMENT ORDER FORM

HEALTH CARE PROVIDER (HCP) ORDERS

This student has a severe allergy to _____, which may result in an anaphylactic reaction.

Student's Name: _____ Student's Birth Date: ____/____/____

School: _____ Grade: _____

Emergency Number
for Parents: (Phone) _____ (Cellular) _____ (Pager) _____

HCP Name and Phone Number: _____

Asthmatic: Yes * No *High risk for severe reaction.

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Symptoms:

Respiratory: repetitive coughing, wheezing, and shortness of breath.

Gastrointestinal: nausea and vomiting. May also have cramps and diarrhea.

Skin: itchy, swelling of face or extremities, hives, red and blotchy skin.

Cardiovascular: irregular, rapid heart beat. May also feel faint.

Throat: itching, sense of tightness, hoarseness.

Mouth: itching and swelling of lips, tongue/mouth, difficulty swallowing.

HCP ORDERS AND SPECIAL INSTRUCTIONS:

1. If exposure to allergen is suspected, give: _____

2. If the student exhibits any of the above symptoms, give: _____

3. Call 911 _____

4. Other: _____

5. Expiration/review date _____

These orders must be renewed at the beginning of each school year or before.

Health Care Provider Signature

Date