

**GASTON COUNTY SCHOOLS
PHYSICIAN ORDER AND TREATMENT PLAN FOR STUDENT WITH
ANAPHYLAXIS**

(This form replaces the Authorization of Medication for Students in School Form.)

STUDENT'S NAME: _____ BIRTHDATE: _____
 DIAGNOSIS: _____
 KNOWN ALLERGEN: _____

TREATMENT PLAN

MEDICATION/DOSAGE: _____
 INDICATIONS/INSTRUCTIONS: _____

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 INDICATIONS/INSTRUCTIONS: _____

Student understands and has been instructed in self-administration of the medication(s) for anaphylactic reactions. YES/NO

Student has demonstrated the skill level necessary to self-administer the medication(s) for anaphylactic reactions. YES/NO

EMERGENCY PLAN

CALL 911 IF EPINEPHRINE AUTO-INJECTOR IS ADMINISTERED OR FOR SIGNS OF SEVERE ANAPHYLAXIS.

COMMENTS _____

I hereby give permission for school personnel to contact my child's physician and exchange information regarding my child's health needs.

Parent/Guardian (Signature)	date	Health Care Provider (Signature)	date	Printed Physician name or clinic stamp
		Telephone #		

School Nurse Signature _____ Date _____

Session Law 2005-22, House Bill 496, chapter 115c, article 26a-375.2). If a student uses anaphylaxis medication prescribed for the student in a manner other than as prescribed, a school may impose on the student disciplinary action according to the schools disciplinary policy. A school may not impose disciplinary action that limits or restricts the student's immediate access to the anaphylaxis medication.