



*Only fill out this form if your child requires special doctor ordered protocols.

Physician's Emergency Medical Protocol

Child's Name: _____ Date of Birth: _____

Physician's Name: _____ Telephone #: _____

Child's Diagnosis: _____

Specific Insect/ Food Allergen: _____

Has Asthma? Yes or No (**Circle one**)

If the child is stung, or has ingested or thinks he/she has ingested the above named food:

PLEASE IDENTIFY BY NUMBER (1,2,3...) THE DESIRED MEDICAL PROTOCOL

_____ Observe child for symptoms of anaphylaxis

_____ Administer Benadryl _____ (state specific dose)

_____ Administer Epinephrine (**Epi-pen, jr.**) 0.15 cc before symptoms occur

_____ Administer Epinephrine (**Epi-pen, jr.**) 0.15 cc if symptoms occur

_____ Administer Epinephrine (**Epi-pen**) 0.30 cc before symptoms occur

_____ Administer Epinephrine (**Epi-pen**) 0.30 cc if symptoms occur

_____ Other (if Diabetic specify protocol)

Any child treated for anaphylaxis will be transported to the nearest Emergency Room

Physician's Signature

Date

Parent/Guardian Authorization:

I hereby request that the above medication, ordered by the physician for my child
_____ be administered by authorized school personnel.

Signature _____ Relationship to child _____

Phone Number _____