*Attach student photo here.

Country Day School LLC

ALLERGIES/ ANAPYHLAXIS MEDICATION ADMINISTRATION FORM
2026-2027

Student Last Name: _____ First Name:_____ Middle:_____

Date of birth: _____ Weight:_____

Teacher's Name _____

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergies: _____

History of asthma? ____ Yes (If yes, student has an increased risk for a severe reaction; complete the Asthma MAF for this student.)
____ No

History of anaphylaxis? _____ Yes (Include date) _____No

If yes, system affected: ____Respiratory ____ Skin ____ GI ____ Neurologic

Treatment: _____

Does this student have the ability to recognize signs of allergic reactions? ____ Yes ____ No

Select In-School Medications

SEVERE REACTION

A. Immediately administer epinephrine, then call 911.

Give intramuscularly in the anterolateral thigh for any of the following signs/ symptoms (retractable devices preferred):

-shortness of breath, wheezing, or coughing -fainting or dizziness -lip or tongue swelling that bothers breathing
-pale or bluish skin color-tight or horse throat -vomiting or diarrhea (if severe or combined with other symptoms)
-trouble breathing or swallowing -many hives or redness over body
-other: _____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):

_____

Even if child has MILD signs/symptoms after a sting or eating these foods, give epinephrine.

B. If no improvement, or if signs/symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of three doses)

☐ If this box is checked, give antihistamine after epinephrine administration (order antihistamine below)

MILD REACTION

A. Give antihistamine: Name:_____

Dose:_____as needed for any of the following signs/symptoms: *itchy nose, sneezing, itchy mouth *a few hives or mildly itchy skin *mild stomach nausea or discomfort *other symptoms:_____

OTHER MEDICATION

Give Name: _____ Dose:_____

Frequency: _____

Specify signs, symptoms, or situations: _____

_____

If no improvement, indicate instructions: _____

_____

Conditions under which medication should not be given: _____

_____

Home Medications (include over the counter) ☐ None

_____

Health Care Practitioner

Last Name (Print): _____ First Name (Print): _____

Signature: _____ Date: _____

Address: _____ Telephone: _____

PARENTS/ GUARDIANS: READ, COMPLETE, AND SIGN. BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school office my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
   - All prescriptions and "over the counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child.
     - Prescription medicine must have the original pharmacy label on the bottle or box. Label must include: 1.) My child's name, 2.) Pharmacy name and phone number, 3.) My child's healthcare practitioner's name, 4.) Date, 5.) Number of Refills, 6.) Name of Medicine, 7.) Dosage, 8.) When to take the medicine, 9.) How to take the medicine, and 10.) any other directions.
   - I must immediately tell the school office about any change in my child's medicine or the healthcare practitioner's instructions. Country Day School, LLC (CDS) and its staff involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize CDS to provide these services to my child.
   - The medication order in this MAF expires at the end of my child's school year, or when I give the school office a new MAF (whichever is earlier). When this medication order expires, I will give the office a new MAF written by my child's healthcare practitioner.

Student Name:_____ Date of Birth:_____

Parent/ Guardian Name (Print):_____

Parent/ Guardian Signature:_____ Date Signed:_____

Parent/ Guardian Address: _____

Parent/ Guardian Cell Phone:_____ Other Phone:_____

Other Emergency Contact Name/ Relationship:_____

Other Emergency Contact Phone:_____