

Form H Medication Administration Record

Calvary Lutheran Church of Golden Valley, 7520 Golden Valley Road, Golden Valley, MN 55427

I, _____, give permission for Calvary Lutheran Church to
Parent
give _____ the following medication.
Full First & Last Name

Medication: _____ Amount/Dose: _____

Time of Dose/Frequency: _____

Reason for Medication: _____

Possible Side Effects: _____

Food Allergy Action Plan

Allergy To: _____

Student's name _____ Date of Birth _____

Asthmatic Yes* _____ No _____ * High risk for severe reaction

Signs of an Allergic Reaction

Systems:

Symptoms:

Mouth	itching & swelling of the lips, tongue, or mouth
Throat*	itching and/or a sense of tightness in the throat hoarseness and hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart*	"thready" pulse, "passing-out"

The severity of symptoms can quickly change.

****All above symptoms can potentially progress to a life-threatening situation.***

Action for Major Reaction

1. If ingestion is suspected and/or symptom(s) are: _____
Give _____ IMMEDIATELY!
Medication/dose/route
Then call:

2. Rescue Squad 9-1-1

3. Mother _____, Father _____ or emergency contacts.

4. Dr. _____ at _____.