

Westford Public Schools

EPIPEN® ADMINISTRATION ORDERS, CONSENT, AND PLAN OF CARE

Name: _____ Grade: _____ D.O.B. _____
 Name of Licensed Prescriber: _____ School: _____ Sex: M / F
 Diagnosis: _____
 Food Drug Allergies: _____
 Medication: _____ Dosage: _____ Frequency: _____
 Possible Side Effects: _____
 Is it absolutely necessary for this medication to be taken at school? Y / N
 Date of Order: _____ Expiration of Order: _____ Expiration of Medication: _____
 Quantity of medication received by the school nurse and date: _____

To be completed if not in violation of confidentiality:
 Please list all medications the child is receiving, including those given during and after school hours.
 Please include adverse reactions and side effects.

Signature of Physician: _____ **Date:** _____

PARENTAL CONSENT

(Please initial)

- ____ Student should always take medication on a field trip.
- ____ Student can miss the medication on field trip days.
- ____ The school nurse may administer the medication ordered above.
- ____ Student may self-administer medication (such as inhalers) at school **and/or** field trips.
- ____ The school nurse may share with appropriate school personnel, information relative to the prescribed medication administration. (e.g. adverse side effects as the nurse determines necessary for the student's health and safety.)
- ____ A teacher or chaperone deemed qualified by the school nurse may administer this medication on field trips.

Please list any emotional response and need for support: _____

Please note: I understand that I may retrieve the medication from the school at any time, and that the medicine will be destroyed if it is not picked up following termination of the order.

Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____

Relationship to Student: _____ Date: _____

Allergy Action Plan and Individual Health Care Plan

Student's Name: _____ DOB: _____ Grade: _____ Bus: _____

Place Photo Here

ALLERGY TO: _____ Documented: _____ Date: _____ Suspected: _____

STEP 1: TREATMENT (TO BE COMPLETED BY M.D.)

Symptoms:

- | | | |
|--|---------------|-----------------|
| ❖ A food allergen has been ingested, but no symptoms: | o Epinephrine | o Antihistamine |
| ❖ Mouth Itching, tingling, or swelling of lips, tongue, mouth | o Epinephrine | o Antihistamine |
| ❖ Skin Hives, itchy rash, swelling of the face or extremities | o Epinephrine | o Antihistamine |
| ❖ Gut Nausea, abdominal cramps, vomiting, diarrhea | o Epinephrine | o Antihistamine |
| ❖ Throat* Tightening of throat, hoarseness, hacking cough | o Epinephrine | o Antihistamine |
| ❖ Lung* Shortness of breath, repetitive coughing, wheezing | o Epinephrine | o Antihistamine |
| ❖ Heart* Weak or thready pulse, low blood pressure, fainting, pale, blueness | o Epinephrine | o Antihistamine |
| ❖ Other* _____ | o Epinephrine | o Antihistamine |
| ❖ If reaction is progressing (several of the above areas affected) give: | o Epinephrine | o Antihistamine |

* Potentially life-threatening. The severity of symptoms can quickly change

STEP 2: DOSAGE (TO BE COMPLETED BY M.D.)

Epinephrine: inject intramuscularly (circle one) Epipen®, Epipen® Jr., Twinjet® 0.3 mg, Twinjet® 0.15 mg (see reverse side for instructions) **NOTE: the 2nd dose of Twinjet® must be administered by a health care provider.**

Antihistamine: Give _____ Medication/dose/route (Please note: Benadryl will not be delegated on a field trip)

Doctor's Signature: _____ **Specialty:** _____ **Date:** _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 3: EMERGENCY CALLS (TO BE COMPLETED BY PARENT/GUARDIAN)

1. Call 911: State: "Epipen® has been administered and additional epinephrine may be needed."

Home phone	Cell phone	Work phone
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2. Call Mother/Legal Guardian: _____

3. Call Father/Legal Guardian: _____

4. _____: _____

5. _____: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO TAKE CHILD TO MEDICAL FACILITY!

I understand that Benadryl will not be delegated on a field trip.


Parent/Guardian's Signature: _____ **Date:** _____

Allergy Action Plan and Individual Health Care Plan

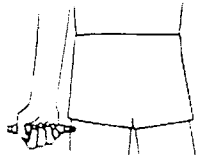
Student Name: _____ DOB: _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

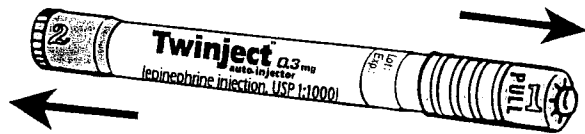


- Hold black tip near outer thigh (always apply to thigh).




- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions



- Remove caps labeled "1" and "2."
- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



Epipen® Location #1 _____ Exp Date: _____

Epipen® Location #2 _____ Exp Date: _____

Please initial:

- _____ My child will carry his/her Epipen® while at school.
- _____ My child knows how to self administer his/her Epipen®.
- _____ My child will carry his/her own Epipen® on the school bus to and from school.
- _____ My child will carry his/her own Epipen® on a field trip.
- _____ My child wears a medic alert bracelet.
- _____ I give my permission for the school nurse to share this information with school personnel.
- _____ I am interested in participating in the training/orientation in my child's classroom.
- _____ I will provide a snack box for my child while in school.
- _____ I want my child to eat at a peanut/nut free table in the cafeteria and/or classroom. (Please note: your child is encouraged to invite a classmate to eat at his table with other food allergic students who have either brought their lunch from home or purchased a school lunch. However, for your child's safety, non-food allergic students must purchase a school lunch in order to sit at the peanut/nut free table.)

Please note: For your child's safety, students with food allergies should ONLY consume foods and drinks provided by you and should not share food. Also, you are encouraged, if possible, to accompany your child as a chaperone on field trips.

Signature of Parent/Legal Guardian: _____ Date: _____