

MAYNARD

PUBLIC SCHOOLS

MEDICATION ADMINISTRATION FOR STUDENT WITH SEVERE ALLERGY

To Be Completed By Physician and Parent

SCHOOL YEAR _____

STUDENT _____ BIRTH DATE _____ TEACHER _____

→ → → → → **TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER** ← ← ← ← ←

DIAGNOSIS/ALLERGIC TO: _____

ALLERGY DOCUMENTED BY: Prior Reaction – date/describe: _____
 Allergy Testing – date/describe: _____
 Other: _____

TYPE OF EXPOSURE RISK: Ingestion Skin Contact Inhalation Other

DOSAGES: Epinephrine – auto-inject IM (circle one): EpiPen (0.3mg) EpiPen Jr (0.15mg)
Antihistamine – medication/dose/route: _____
Other Treatment or medication/dose/route: _____

PRESCRIBED TREATMENT: **ADMINISTER CHECKED MEDICATION STAT**

If exposure/ingestion of allergen but ***no immediate symptoms:*** EpiPen Jr EpiPen Antihistamine

If exposure/ingestion of allergen ***with symptoms:*** EpiPen Jr EpiPen Antihistamine

Other: _____

Symptoms *may* include: itching, tingling, swelling, tightening of throat, shortness of breath, wheezing, coughing, hives, nausea, vomiting, diarrhea, low BP, cyanosis, fainting.

→ → → **If EpiPen is administered, EMS (911) will be summoned for transport to nearest ER.** ← ← ←
Student will be placed in supine position with legs raised until arrival of ambulance.

- EpiPen shall be kept in the School Nurse's Office except during field trips.
- A second EpiPen may be kept in the student's classroom.
- This student must carry an EpiPen with him/her at all times. He/she is capable and responsible for self-administration but must notify staff immediately if used.

Physician/Licensed Prescriber Signature: _____ Date: _____

Stamp or Print Physician's Name: _____

Address: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____