Burlington Public Schools

Allergy Medication Administration Plan and Consent

Student: ______________________________ Date of Birth: ________ Weight: ______ Grade: ______ Homeroom: ______

Allergy to: ____

Is student ASTHMATIC? ☐ Yes ☐ No **Diagnosis Oral allergy syndrome?** ☐ Yes ☐ No

Past Reaction Type (Rash vs. Vomit/Breathing changes) ____

Extremely reactive to the following foods: ____

THEREFORE:

 Give epinephrine immediately for ANY symptoms if the allergen was likely eaten. ☐ Yes ☐ No

 Give epinephrine immediately if the allergen was definitely eaten, even if no symptoms noted. ☐ Yes ☐ No

Are there situations where this child can consume or touch the allergen without symptom development? (i.e. wheat allergy, but may touch play dough, egg allergy but eats eggs cooked in baked goods)____
(if so ensure your MD comments.*)

The **Health Care Provider** must write orders.

Please Note: *Due to State Laws, the nurse **cannot** delegate assessment skills and/ or the administration of "as needed" medications such as Benadryl. If there is a question whether a child, who has been prescribed an Epi-Pen is having an allergic reaction, the Epi-Pen will be administered. It is the policy of Burlington Public Schools not to use Twin-Jet Epinephrine Systems as a method of treatment.*

1. Give Medication(s)

Medication(s)	Dose	Route	Frequency	When to Use	Side Effects

- It is my professional opinion that this child should be provided with a table section where efforts are made to exclude the listed allergen ________________. Yes__________ No______
- Additional school environment measures needed or exceptions: ____*

Prescriber's Name (Print) ______________________________________ Phone # _________________________

Prescriber's Signature ____**Date** ___________________

Must be manual, may not be rubber-stamped, according to the Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices & Policy Guidelines adopted Aug. 1, 1989 and amended Dec. 12,2001.

2. After epinephrine given, call 911

3. Contact Parents/Guardians

Parent/Guardian ____________________________/________________/____________________/___________________
(Print Name) (Home #) (Cell #) (Work #)

Parent/Guardian ____________________________/________________/____________________/___________________
(Print Name) (Home #) (Cell #) (Work #)

Emergency Contact__________________________/_________________/____________________/___________________
(Relationship to child) (Home #) (Cell #) (Work #)

4. Call Physician (print name) ________________________________ Phone # ______________________________

Complete guardian consents on the back of this form

Allergy Medication Administration Plan and Consent …continued

Student: ______________________________ Date of Birth: ________ Weight: ______ Grade: ______ Homeroom: ______

Field Trip In event of field trip: (Please initial all that apply)

____ *My child may self-administer if my child can demonstrate competency. **(*Nurse to assess and evaluate "Yes" below**).

____ I or my designee will attend my child's field trips and assume responsibility for my child's medical & medication needs.

____ I give permission for a responsible adult, trained by the school nurse, to give my child this medication. **Please Note:** *Due to State Laws, the nurse* ***cannot*** *delegate assessment skills and/ or the administration of "as needed" medications such as, but not limited to, Benadryl or Albuterol. However, due to a State Waiver, the nurse is permitted to train staff in the administration of an Epi-Pen to children who have them prescribed. If there is a question that a child, who has been prescribed an Epi-Pen, is having an allergic reaction, the Epi-Pen will be administered and the emergency services will be summoned..*

For my child's safety, I give the school nurse permission to:

Yes ______ No ______ Share information relative to my child's allergy with appropriate personnel as necessary for my child's safety and health.

Yes ______ No ______ Have my child sit at a section of the lunch table where efforts are made to avoid ________ (*food allergen*).

Yes ______ No ______ Photograph and display my child's picture to the appropriate staff, so they are able to recognize my child has an Epi-Pen prescribed for an allergic condition.

Yes ______ No ______ The school nurse may speak to the listed Health Care Provider for clarification for allergy concerns.

Parent/Guardian's Signature ________________________________ Date ____

Please list all the medications the child currently takes *(if this changes at any time during the school year, please contact the school nurse):* ____

Please note: *All medications must be in their original and/or pharmacy- labeled containers and delivered to the nurse by a responsible adult and may be retrieved by the parent/guardian at any time. Medications will be disposed of if they are not picked up within one week following the order's termination or at the completion of the last day of school.*

For Health Office Use Only

Student has demonstrated competency in medication self administration:

___Yes ___No ______Date Nurse's name printed: ______________________ Nurse's' signature: ______________________

___Yes ___No ______Date Nurse's name printed: ______________________ Nurse's' signature: ______________________

___Yes ___No ______Date Nurse's name printed: ______________________ Nurse's' signature: ______________________

Medication storage location: ________________________________ Date Medication EXPIRES: ____________

Rev 11/17