SAYRE SCHOOL
MAKE·YOUR·MARK

Epinephrine & Severe Allergy Plan

2022-2023 School Year

A parent/guardian and the student's health care provider must complete this form in order to authorize Sayre School personnel to treat the student. Parents must update this form prior to the start of each school year.

Student Information:
Name: _____ DOB: _____ Grade: _____
Parent/Guardian names and cell phone numbers: _____
_____

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Allergic to: _____ Asthma: ☐ Yes ☐ No
Anaphylaxis reaction to: _____

Medications:
Epinephrine Brand or Generic: _____
Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms appear.

☐ **If checked, student will self-carry epi-pen.** This student is capable and has been instructed in the proper method of self-administering the medications named above. All students should have an additional epi-pen in their division office.

Antihistamine Brand or Generic: _____ Dose: _____

Inhaler/Bronchodilator: _____ Dose: _____

Health Care Providers: Please read the information about our procedures on the following page. Your signature confirms the orders above and acknowledgment of our procedures.

Epinephrine will be administered for any or a combination of the following severe symptoms:

- Shortness of breath, wheezing, repetitive cough
- Pale or bluish skin, fainting, weak pulse, dizziness
- Tight or hoarse throat, difficulty breathing or swallowing
- Swelling of the tongue or lips
- Numerous hives or widespread redness
- Repeated vomiting or severe diarrhea
- Severe anxiety, confusion

In these cases:

1) **Inject epinephrine immediately**
2) **Call 911** Tell dispatcher that the person is having an anaphylactic reaction and may need epinephrine
    - If ordered above, administer antihistamine and/or inhaler if wheezing
    - Lay the person flat, raise legs and keep warm. I breathing is difficult or they are vomiting, elevate their head or lie them on their side
    - If symptoms do not improve or symptoms return, administer a 2nd dose of epinephrine about five minutes or more after the last dose.
    - Contact parent/guardian and/or emergency contacts
    - Transport student by EMS to the emergency room or dismiss student to parents if appropriate

For any combination of the following mild symptoms:

- Itchy or runny nose
- Itchy moth
- A few hives, mild itching
- Mild nausea or discomfort

For Mild Symptoms of MORE than one of the above, give epinephrine

For a single mild symptom listed above:

- Administer antihistamine as directed by health care provider
- Stay with the person, alert parent/guardian/emergency contact
- Watch closely for changes. If symptoms worsen, give epinephrine.
- Contact EMS if epinephrine is administered.

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

<u>The above medication order is valid for one year from the date signed by the physician.</u>

MEDICATION GUIDELINES

The administration of medication to students shall be done only in exceptional circumstances where the student's health may be jeopardized without the medication.

Whenever possible, administration of medication should be done at home. Medication prescribed three times per day can be given before school, afterschool, and at bedtime. If a new medication is started, the first dose must be given at home, unless it is a rescue medication.

The school will adhere to the following guidelines as it pertains to medication:

- Administration of prescription medication by school personnel must only be done according to the written order of a licensed prescriber and written authorization of parent / guardian and Licensed School Nurse, regardless of the student's age.
    - Mixed dosages in a single container will not be accepted for administration at school.
    - If a half tablet is required for a correct dosage, it is the parent's / guardian's responsibility to provide pre-cut tablets for administration at school.
    - Altered forms of medication will not be accepted or administered at school.
    - Narcotics / medical cannabis will not be administered at school.
    - Aspirin-containing products will not be administered at school.
    - Only FDA approved treatments will be provided at school. (No essential oils)

- All medication (prescription and non-prescription) must be brought to and from school by a parent / guardian in its original container. The following information must be on the prescribed container label:
    - Student's full name
    - Name and dosage of medication
    - Time and directions for administration at school
    - Physician / licensed prescriber's name
    - Date (must be current)

- New consent from a licensed health care provider and parent / guardian signatures must be received each school year.

- A new medication consent form is required when the medication dosage or time of administration is changed.

- When a long-term daily medication is stopped, a written physician / licensed prescriber's order is requested.

- Medication will be kept in a locked cabinet in the Nurse's Office unless authorized by the Licensed School Nurse, and must not be carried by the student.

PARENT/GUARDIAN AUTHORIZATION

- I request the medication(s) listed on page one be given to my child during regular school hours as ordered by the physician/licensed prescriber. (Note: This does not pertain to after-school activities.)
- I give permission for the medication to be given by designated personnel.
- For prescription medication, I will provide the above-mentioned medication in the pharmacy labeled container.
- I authorize the Licensed School Nurse or designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.
- I authorize the Licensed School Nurse or designee to communicate with appropriate school personnel regarding this medication for my child.
- I release Sayre School and school personnel from any liability in relation to the administration of this medication.
- I have read and understand the Medication Guidelines included in this form.

Parent Name: _____

Parent Signature: _____ Date: _____