

**PLACE
PICTURE
HERE**

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: **Yes (higher risk for a severe reaction)** **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____








THEREFORE:

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 are apparent.

FOR ANY OF THE FOLLOWING:





SEVERE SYMPTOMS

 LUNG Shortness of breath, wheezing, repetitive cough	 HEART Pale or bluish skin, faintness, weak pulse, dizziness	 THROAT Tight or hoarse throat, trouble breathing or swallowing	 MOUTH Significant swelling of the tongue or lips
 SKIN Many hives over body, widespread redness	 GUT Repetitive vomiting, severe diarrhea	 OTHER Feeling something bad is about to happen, anxiety, confusion	OR A COMBINATION of symptoms from different body areas.

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

 NOSE Itchy or runny nose, sneezing	 MOUTH Itchy mouth	 SKIN A few hives, mild itch	 GUT Mild nausea or discomfort
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FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

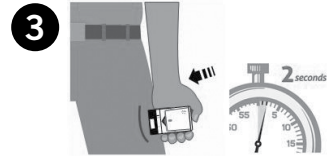
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

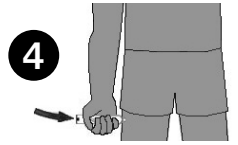
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



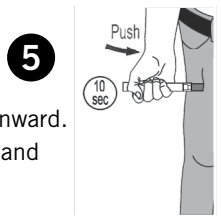
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

**NORTHERN YORK COUNTY SCHOOL DISTRICT
SELF-ADMINISTRATION OF ASTHMA INHALER/EPINEPHRINE
AUTO-INJECTOR PERMISSION FORM**

Name _____ Name of Medication _____ Date _____

School _____ Grade _____ DOB _____

Criterion for student self-administration of Asthma Inhaler and/or Epinephrine Auto-Injector

The prescribed medication shall be maintained in a clearly labeled original container noting the child's name, the medication name, and the time and/or special circumstances for self-administration.

Student is able to:

- Verbalize symptoms/situation related to the need for medication use.
- Demonstrate the correct technique for self-administration of the medication.
- Follow the emergency action plan as prescribed by physician.
- Inform the school nurse immediately after self-administering asthma inhaler or epinephrine auto-injector.
- Store medication in a secure location where it is easily accessible.

I have received instruction from my prescriber on proper safety precautions for the handling and disposal of the asthma inhaler and/or epinephrine auto injector. I will take responsibility for carrying and self-administration of my asthma inhaler and/or epinephrine auto-injector at school. I have read and understand the school policy regarding self-administration and possession of this medication. If I violate this school policy, I understand that it will result in loss of privilege to self-carry my medication as well as possible disciplinary action in accordance with Board policy. **I understand that in order for me to self-administer and carry my medication, I must meet with the school nurse for final approval of this process.**

STUDENT SIGNATURE _____ **Date** _____

I certify that my son/daughter is able and responsible to carry and self-administer their asthma inhaler and/or epinephrine auto-injector. I give permission for self-administration and possession of the ordered medication for my child to use during school hours, at any time while on school property, at any school-sponsored activity, and during the time spent traveling to and from school and school-sponsored activities. I understand and consent to the stipulations of the school policy regarding self-administration of medication. I understand my child may lose this privilege if the policy is violated. I understand and agree that in the event of an emergency, a district employee may administer emergency medication (e.g epinephrine, inhalers, etc.) when s/he believes, in good faith, that a student needs emergency care. I also agree that the school entity bears no responsibility for ensuring that the medication is taken. I understand that emergency medical services will always be notified when epinephrine is administered, whether or not the student manifests any symptoms of anaphylaxis. I will inform the school nurse if there are changes in this medication.

I hereby release, indemnify, and hold harmless the Northern York County School District, its employees, and its agents against any claim(s) arising out of the administration or self-administration of medication pursuant to this permission form, or related to the benefits or consequences of the prescribed medication. **I understand this permission form must be completed by both a physician and the school nurse prior to my child self-administering or carrying his/her emergency medication.**

PARENT/GUARDIAN SIGNATURE _____ **Date** _____

It is my professional opinion that this student may carry and self-administer his/her medication according to the orders prescribed on the attached emergency action plan.

PHYSICIAN SIGNATURE _____ **Date** _____

The student, _____ has demonstrated competency for self-administration and responsible behavior in use of the prescribed medication.

SCHOOL NURSE SIGNATURE _____ **Date** _____

This authorization is good for one school year and must be renewed each year.