

Westborough Public Schools

Westborough, MA 01581

MEDICATION ADMINISTRATION FOR STUDENT WITH SEVERE ALLERGY

School Year _____ to _____

Student _____ Birthdate _____ Teacher _____

* * * * * *To be completed by Physician or Licensed Prescriber* * * * * *

ALLERGY TO: _____ History of anaphylaxis: Yes No

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 (0.3 mg.) EpiPen Jr. (0.15 mg.)

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, RESCUE SQUAD will be summoned for transport to nearest ER.** ~
Student will be placed in supine position with legs raised until arrival of ambulance.

AUTHORIZATION

EpiPen shall be kept in the School Nurse's Office except during field trips.

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 done.

Physician/Licensed Prescriber Signature: _____ Date _____

Stamp or print: Name _____

Address _____ Phone _____

Parent/Guardian Signature: _____ Date _____

My child may be photographed for an individualized school health alert form, distributed to appropriate staff.

