HILLVIEW ELEMENTARY SCHOOL
GROVE CITY AREA SCHOOL DISTRICT

MRS. TAMMI MARTIN
PRINCIPAL
MR. KEVIN PERSCH
ASSISTANT PRINCIPAL
MRS. REBECCA TRINCHESE
GUIDANCE COUNSELOR

Dear Parent/Guardian:

We are concerned about the safety and well-being of the students who have been identified as having asthma and life-threatening allergies. It is important that they have access to the necessary medication for controlling symptoms of asthma and anaphylaxis as quickly as possible.

The Pennsylvania General Assembly passed a law requiring that schools have a policy to allow students to carry Epi Pens and inhalers with them. The Grove City Area School District has written such a policy as well. **I have attached a prescription form/action plan which will need to be completed by your child's physician and signed by a parent or guardian. The form must be on file in the nurse's office for any student who uses or carries an inhaler or an Epi Pen. The decision about whether or not your student self-carries or keeps his/her medication in the nurse's office is best made by the parent and physician.**

Please contact me if you have any other questions or concerns.

Respectfully,

Jenniler Heaney, RN, CSN
Certified School Nurse

482 EAST MAIN STREET • GROVE CITY, PA 16127
PHONE: 724-458-7570 • FAX: 724-458-0444

Medication Administration Consent and Licensed Prescriber Order
Grove City Area School District

Student Name: _____ **Date/Time:** _____
School: _____ **Teacher/Grade:** _____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a **Medication Administration Consent** form signed by the student's parent/guardian **and** a **Medication Order** from a licensed prescriber. **All medications must be in an original prescription bottle/container from a pharmacy. All medication(s) must be delivered to a license nurse. A student may not transport medication.**

Parent/Guardian Consent:

I give my permission form my child, _____, to receive the following medication as ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child's licensed prescriber's directions.

Parent/Guardian signature: _____ **Date:** _____
Parent/Guardian name printed: _____ **Phone:** _____

Nurses Signature: _____ **Date/Time Rec'd:** _____
Amt. Rec'd: _____

FOR PHYSICIAN USE

Licensed Prescriber Medication Order:

Patient's name: _____ **Date:** _____
Name of medication: _____
Route and dosage: _____
Time of administration: _____
Directions: _____
_____
Discontinuation date: _____
Allergies: _____

Licensed prescriber signature: _____

Licensed prescriber name printed: _____ **Phone:** _____

Food Allergy Action Plan

Place Child's Picture Here

Student's Name: _____ D.O.B: _____ Teacher: _____

Allergy to: _____ Asthmatic: Yes* ☐ No ☐ *Higher risk for severe reaction

■ STEP 1: TREATMENT ■

Symptoms:		Give Checked Medication**: **(To be determined by physician authorizing treatment)
▪	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one, and see reverse side for instructions)

EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg Adrenaclick™ 0.3 mg Adrenaclick™ 0.15 mg

Antihistamine: give (medication/dose/route)_____

Other: give (medication/dose/route)_____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

■ STEP 2: EMERGENCY CALLS ■

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number: _____
3. Parent _____ Phone Number(s): _____
4. Emergency contacts:
   a. Name/Relationship _____ Phone Number: _____
   b. Name/Relationship _____ Phone Number: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature _____ Date _____

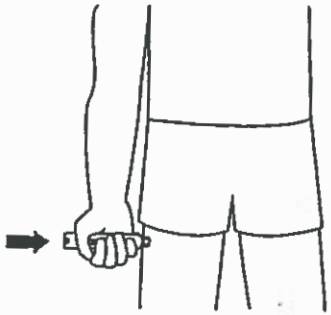
Doctor's Signature _____ Date _____
(Required)

Staff Members Trained in Epinephrine Administration:

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

- Remove caps labeled "1" and "2."
- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

- Slide yellow collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

- Remove GREY caps labeled "1" and "2."
- Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

Once epinephrine is used, call the Rescue Squad and request an ambulance equipped with epinephrine and a responder trained to administer this medication. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

FAAN

Feb. 2010