



# East Helena Public Schools

School District No. 9

P.O. Box 1280 \* East Helena, MT. 59635

Superintendent/ Administration Office (406) 227-7700

Eastgate Elementary School (406) 227-7770 \* Prickly Pear Elementary (406) 227-7720

Radley Elementary School (406) 227-7710 \* East Valley Middle School (406) 227-7740

East Helena High School (406) 227-7700

***"Success For All"***

Eastgate Elementary Fax: 406-227-8479 \* EVMS Fax: 406-227-9730

Radley Fax: 406-227-7713 \* Prickly Pear fax: 406-227-3369



## Epipen Permission Form

Student's Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_

Time \_\_\_\_\_ Dosage \_\_\_\_\_

Special instructions \_\_\_\_\_

Possible side effects \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature/Date

\_\_\_\_\_  
Parent's Signature/Date

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\_\_\_\_\_ This student is capable of administering his/her epipen appropriately and may carry it with him/her.

\_\_\_\_\_ This student's medication should be kept in the nurse's office.

\_\_\_\_\_ The allergy action plan has been completed and signed by both parent and physician.

Physician's signature \_\_\_\_\_

Parent's signature \_\_\_\_\_



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## **Benadryl Medication Permission Form**

Student's Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_

Time \_\_\_\_\_ Dosage \_\_\_\_\_

Special instructions \_\_\_\_\_

Possible side effects \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature/Date

\_\_\_\_\_  
Parent's Signature/Date

From time to time, it may be necessary for your child to take prescription medicine for treatment of an illness. Medication ordered to be taken less than 4 times a day can and should be taken at home. However, if medicine must be taken 4 times a day, or at a specific time scheduled during school hours, the school nurse, as mandated by state law, may dispense medications **ONLY WITH THE FOLLOWING:**

1. Medication order signed by the physician
2. Parental authorization, signed by the parent
3. Original pharmacist labeled bottle





Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

**PLACE  
PICTURE  
HERE**

**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.

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

**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: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

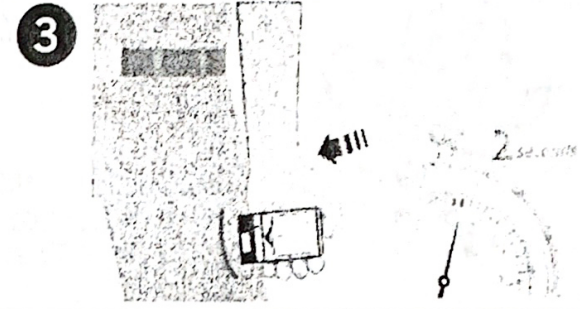
Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_





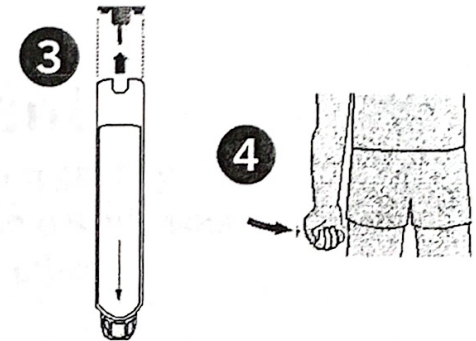
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



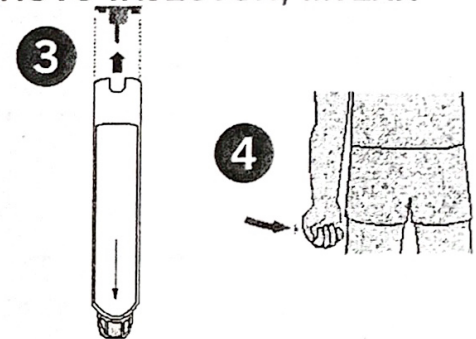
## HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

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.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



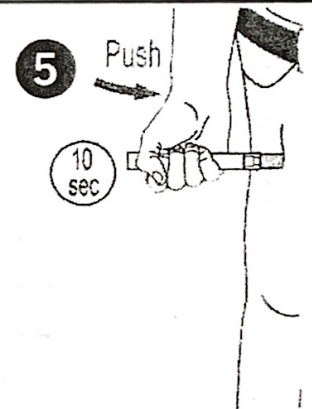
## HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

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



## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

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



## 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: \_\_\_\_\_





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## Severe Allergies Health Assessment

The following assessment questions will help me to have more information regarding your son/daughter's health condition in order to provide the best care possible while your they are at school. Please answer the following questions, and include any other information you feel that we should know.

1. What specific foods has your child previously reacted to?

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2. What types of reactions have you seen in the past?

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3. Has your child ever been hospitalized or seen in the Emergency Room due to an allergen exposure? \_\_\_\_\_

4. Does your child have a history of Asthma? \_\_\_\_\_

5. Please list any current medications your child is taking

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6. Will your child be riding the bus to or from school? \_\_\_\_\_

7. Are there any special lunchroom accommodations you feel are necessary? \_\_\_\_\_

8. Please share any additional information that you feel may be helpful for me to know.

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In case of an emergency it is very important that we are able to reach you. Please share your contact information.

Name \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_