AMSA
ADVANCED MATH & SCIENCE ACADEMY
INTEGRITY · EXCELLENCE · COMMUNITY

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Dear Parents/Guardians

If an Epinephrine Autoinjector (EpiPen) is required for administration for the next school year (August 2025-June 2026) please remember to follow these important steps:

Medical Orders must be written and dated after July 1st, 2025. Medical orders are only active for the current school.

- Medical providers must provide **medication orders** that include the name of the medication, form of medication (epinephrine autoinjector), frequency, times of administration, diagnosis for which medication is being ordered and any side effects or specific directions/information for administration.
- Medical providers must provide an (1.)**Allergy Action Plan and (2.) Please review and sign with a medical provider the Emergency Action Plan for campus non-medical staff when a nurse is not on campus/after school activities/field trips and bus drivers.**
- **PLEASE NOTE IF A NURSE IS NOT ON A FIELD TRIP BENADRYL CAN NOT BE GIVEN-ASK YOUR MEDICAL PROVIDER TO MAKE NOTE OF THIS- EPIPEN WILL BE USED AND 911 CALLED.**
- Please bring medications to school before the first day of classes. They must be in the original pharmacy packaging with your student's name on it and non-expired. **You may call the Health Office after August 20, 2025, to arrange a drop-off.** No student is allowed to carry any medications to school, even over-the-counter medication.
- Please review the AMSACS medication administration policy.
- **No student will be allowed to attend a field trip until their allergy paperwork is completed, and the student has brought their Epinephrine autoinjector to the Health Office prior to the event.**

PARENT/GUARDIAN EPINEPHRINE AUTO INJECTOR MEDICATION CHECK

Checklist for Required Paperwork for **Epinephrine Autoinjectors**

Documents from the medical provider needed:

1. _____ Medical Order Form
2. _____ Allergy Action Plan/ Health Care Plan for School
3. _____ Sign The Allergy Emergency Action Plan for Non-Medical Staff/Bus Driver/ After School Activities

Parent to Complete:

1. _____ Parent's Permission for Epinephrine Autoinjector Administration
2. _____ Epinephrine Contract to carry if applicable
3. _____ Parent's Permission for Antihistamine (if applicable and ordered by medical provider)
4. _____ Allergy History
5. ____ Sign The Allergy Emergency Action Plan for Non Medical Staff/Bus Driver/After School Activities

Please be aware that if you feel your child has needs beyond the medical provider's allergy/asthma action plans you may call Guidance for a 504 Plan.

If you need this information translated, please copy and paste it into Google Translate. The link to Google Translate is http://translate.google.com/

Advanced Math and Science Academy Charter School

Parent/Guardian Permission/ Medication Administration Plan (MAP) for Epinephrine Autoinjector (EpiPen) 2025-26

Student Name: ____ DOB:_____________ Grade: ___________ Name of Licensed Prescriber: ____________________________ Phone Number: ____ Emergency Contact; Name/Number: ____	1.Parent/Guardian Name:_________________________________ Home Phone:____ Cell Phone:____ Parent/Guardian Name: __________________________________ Cell Phone:____

Name of Medication: ____ Date of Medical Order (received after July 1, 2025):__________________
Diagnosis: ____ Duration of Medication (Start Date/end Date):______________________

Allergies to Food or Medication: (Specify Allergy the EpiPen is for) ____

Other medication being taken by my student (*if not in violation of confidentiality*):____

( ) I give permission for my child to self- administer their epinephrine autoinjector, if the school nurse determines it is safe and appropriate.
*******If a student needs to use their EpiPen at school they must notify the nurse or staff member and 911 will be called.**

**** If the student will be self-carry, please fill out second page "Contract for Permission to Carry and Self Administer Epinephrine Autoinjector"

How do you want to handle EpiPen administration during times when your child is attending a school function/event, after school hours (clubs/sports, etc.), during off school activities during day/overnight field trips? (Please check one only)

a. ☐ COP (Carries on Person at all times)
b. ☐ FTAS (Carries only on field trips and after school activities)
c. ☐ DNC (Does not carry- Chaperone to carry and be with student during entire event)
d. ☐ Parent to attend field trip/activity

( ) I understand that a parent/guardian must drop off medication to the school nurse and it must be in it the original pharmacy packaging with student's name and the appropriate label.

( ) I give permission to the school nurse or school personnel trained/designated by the school nurse to administer the above medication to my child. Per the medical orders/ Allergy Action plan *******If an EpiPen is administered 911 will be called.**

( ) I give permission to the school nurse to share with appropriate school personnel the information related to the prescribed medication as deemed necessary for my child's health and safety.

( ) I understand that for this medication to be discontinued I need an updated medical note from the student's provider.

***Please be aware that there is no availability for medication administration during after school activities other than staff are trained for EpiPen administration.

Parent/Guardian Signature: ____ Relationship to Student: ___________ Date: __________

If your child's Allergy Action Plan includes an antihistamine (Benadryl/Zyrtec) please complete the second parent permission medication plan. If a nurse is not on a field trip an antihistamine cannot be given, an EpiPen will be administered and 911 called.

FOR HEALTH OFFICE USE ONLY: School Nurse Signature: ____ Date: ________________
Name of the Med. Ordered: ____

Date of Medical Order (received after July 1,2025): ________________ Required Storage :( ) Unlocked;labeled Epinephrine autoinjector ( )COP

Duration of Med. (Start Date;End Date): __/__;___/____Quantity of Med. Received and Date _______________ Expiration Date on EpiPen: ______

Dosage: ______________ Frequency: ______________________ Specific Time: _see medical orders___ Route of Administration: __________

Disposal of medication: ( ) Finished ( )Returned to parent/Guardian ( )Given to Student Nurse's Signature: ___________________ Date: ______

( ) Disposed/Witness__________________________________ Date:________

******* Attach Medical orders & Allergy Action Plan ******** **Edited 6/4/25 MGW**

Attach Student Photo:

Contract for Permission to Carry and Self Administer Epinephrine Auto-injector 2025-26

Name of Student: ____ Grade: 6 7 8 9 10 11 12

To be completed by the Parent/Guardian:

Qualified students will be allowed to carry their Epinephrine Auto-injectors with them in school and on field trips at the discretion of the school nurse. Parents only need to sign the agreement. The school nurse and your child complete the rest of the form. Please contact the School Nurse if there are any changes to your child's medication and/or treatment plan during the school year.

I request that my child be permitted to carry on his/her person the medication that has been prescribed. My child has been instructed in and understands the purpose, appropriate method, frequency and use of his/her medication. My child understands that he/she is responsible and accountable for carrying and using his/her medication. My child understands that he/she will be responsible for carrying and self-administering this medication under the contract agreement level checked below. It is understood that if there is irresponsible behavior or safety risk, the privilege of carrying his/her medication will be rescinded. I will support my child in following the agreement

Parent/Guardian Signature: _____________________________________ _ Date:_______________

CONTRACT AGREEMENT: Check One

- ☐ **COP (Carries on person at all times)**
- ☐ **FTAS (Field Trips/Sports/ After School Activities)**
- ☐ **DNC (Does Not Carry. Chaperone/coach/club leader carries and student to be with them for duration of event)**
- ☐ **Other to be determined by Sch. Nurse:** ________________________________

To be completed by School Nurse and Student

Physicians order for this medication is on file in the Health Office	Yes ☐	No ☐
Student is consistently able to name and identify the correct medication, knows the correct dosage, time it needs to be administrated and purpose of the medication	Yes ☐	No ☐
Student can explain the proper storage requirements of his/her medication and agrees to follow those medication storage requirements	Yes ☐	No ☐
Student demonstrates safe and correct use/administration of medication using an Epinephrine trainer and agrees to carry only the amount of medications required.	Yes ☐	No ☐
Student agrees to be responsible to provide and carry his/her own Epinephrine on field trips/after school activities/sports. If a student forgets to bring his/her Epinephrine, & there is no backup in H.O the student will not be allowed to attend a field trip.	Yes ☐	No ☐
Student agrees that after administering this medication he/she will immediately inform a faculty member/nurse & call 911.	Yes ☐	No ☐
Student realizes his/her responsibility in carrying his/her own medication(s) and agrees ***NEVER*** share the medication(s) with others.	Yes ☐	No ☐
Student agrees to maintain a backup Epinephrine in the health Office	Yes ☐	No ☐
The student understands that the privilege of carrying and administering his/her own medication(s) will be rescinded if he/she does not follow the above agreement.	Yes ☐	No ☐

Expiration date on Medication in Health office is ____________ Expiration date on Medication student is carrying is ________

Amount of medication student can carry ☐ One Epinephrine Autoinjector ☐ Two Epinephrine Autoinjectors

I give permission to notify staff of my plan of self-administration. I understand that if I do not follow the plan of self-administration according to guidelines stated above, or misuse my medication in any way, this agreement will be immediately terminated. Written notification of termination will be sent by nurse to my parents and teachers within 24 hours.

Student Signature: Date:

This student ☐ does ☐ does not demonstrate the required responsibilities
This student ☐ may ☐ cannot carry/self-administer the medication.

Nurse Signature: Date:

Parent/Guardian Permission/ Medication Administration Plan (MAP) for ANTIHISTAMINE Medication 2025-26

Name of Student _____________________________ Date of Birth: ________Grade 6 7 8 9 10 11 12

( ) I consent to having the school nurse administer antihistamine medication as prescribed by my child's physician, according to the Medical Orders/Allergy Action Plan on file at AMSA. ***** After administered a parent will be notified.**

( ) I give permission to the school nurse to share with appropriate school personnel the information related to the prescribed medication administration plan (MAP) as he/she determines appropriate for my child's health and safety.

( ) I understand that there will be no antihistamine available for afterschool and field trip activities when a nurse is not present. Epinephrine will be utilized when no antihistamine is available, and 911 will be called. This is in accordance with Board of registration in Nursing Regulation #244 CMR 3.05 which prohibits the delegation of PRN antihistamine medications when there is not a nurse present.

**** Benadryl/Zyrtec will be utilized from the stock medications at school. If parents have another preference, then the parent will provide the antihistamine in its original container.

□ **Use stock Antihistamine (Benadryl/Zyrtec).**

Parent/Guardian Signature:____ **Relationship to Student:**______________________ **Date:**_____________

Allergy Health History 2025-26 (to be completed by parent/guardian)

Does your child have a diagnosis of an allergy from a healthcare provider? ☐ **No** ☐ **Yes**

a. What is your child allergic to?

☐ Peanuts ☐ Tree Nuts (walnuts, pecans, etc.)
☐ Eggs ☐ Insect Stings
☐ Milk ☐ Fish/Shellfish
☐ Soy ☐ Chemicals
☐ Latex ☐ Vapors
☐ Other:____

b. Age of student when allergy discovered: _____________________

c. How many times has student had a reaction?
☐ Never ☐ Once ☐ More than once, explain:
____

d. Explain their past reaction(s):
____

e. Symptoms: ______________________________________

f. Are the allergy reactions: ☐ Same ☐ Better ☐ Worse

Trigger and Symptoms

a. What are the early signs and symptoms of your student's allergic reaction? (Be specific, include things the student might say____

b. How does your child communicate his/her symptoms? ____

c. How quickly do symptoms appear after exposure to allergens? ☐ Secs. ☐ Mins. ☐ Hours ☐ Days

d. Please check the symptoms that your child experienced in the past:

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, arms, hands, legs)
Mouth: ☐ Itching ☐ Swelling (lips tongue, mouth)
Abdominal: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea
Throat: ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough
Lungs: ☐ Shortness of breath ☐ Repetitive Cough ☐ Wheezing
Heart: ☐ Weak pulse ☐ Loss of Consciousness

Treatment

a. How have past reactions been treated? ____

b. How effective was the student's response to treatment? ____

c. Was there an emergency room visit? ☐ No ☐ Yes, explain(date): _______________________________

d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain(date): ___________________________

e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?
____

f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

g. Have you used the treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment: _________________________

a. Is your student able to monitor and prevent their own exposure? ☐ No ☐ Yes

b. Does your student:

1. Know what food/allergen to avoid ☐ No ☐ Yes
2. Ask about food ingredients ☐ No ☐ Yes
3. Read and understand food labels ☐ No ☐ Yes
4. Tell an adult immediately after an exposure ☐ No ☐ Yes
5. Wear a medical alert bracelet, necklace, watchband ☐ No ☐ Yes
6. Tell peers and adults about the allergy ☐ No ☐ Yes
7. Firmly refuse a problem food/allergen ☐ No ☐ Yes

c. Does your child know how to use emergency medication? ☐ No ☐ Yes

d. Has your child ever administered their own medication? ☐ No ☐ Yes

LIFE THREATENING ALLERGOES EMERGENCY ACTION CARE PLAN FOR SCHOOL 2025-26 NON-MEDICAL: STAFF/BUS DRIVER/AFTER SCHOOL ACTIVITIES

Student: ____ DOB:____________ Grade: ___________ Name of Licensed Prescriber: ____________________________ Phone Number: ____ Emergency Contact; Name/Number: ____	Parent/Guardian Name:_________________________________ Home Phone:____ Cell Phone:____ Parent/Guardian Name: _________________________________ Cell Phone:____

Diagnosis: LIFE THREATENING ALLERGY

Name of Medication: Epinephrine Auto Injector This Student ( ) Carries on Person ( ) Field trip/after school

Allergies to Food or Medication: (Specify Allergy the EpiPen is for): ____

****The severity of symptoms can change quickly. All symptoms can potentially progress to a life-threatening situation. NEVER SEND A STUDENT ANYWHERE WITHOUT AN ESCORT if there are any signs/symptoms of an allergic reaction**

SIGNS/SYMPTOMS of an Allergic Reaction may include:

- **Mouth: Itching, tingling, swelling of lips, tongue, mouth**
- **Skin: Hives, itchy rash, swelling about face or extremities**
- **Gut: Nausea, abdominal cramps, vomiting, diarrhea**
- **Throat: itching or sense of tightening in throat, hoarseness, "barky" cough, difficulty swallowing**
- **Lungs: nasal congestion, shortness of breath**
- **Heart: "thready" pulse, fainting**
- **Brain: anxiety, feeling of "impending doom"**

EMERGENCY PROCEDURE: LIFE THREATENING ALLERGY

1. **If a student exhibits any of the signs/symptoms, keep him/her under close adult supervision and call the Nurse x2475/2409/2472**
2. **The nurse will administer Epinephrine per the student's Medical Orders/Emergency Allergy Action Plan and call 911.**
3. **If the student carries an EpiPen and you have been trained through the Health Office, you may administer the EpiPen if indicated. CALL 911 from a land line, if possible, on campus.**
4. **Notify the nurses or an administrator if nurses are not on campus. Immediately after giving the EpiPen and calling 911.**

FIELD TRIPS:

1. **If a Nurse is not on a field trip, NO Benadryl can be given. An Epinephrine auto injector will be given by a trained staff member and 911 will be called. You must call 911 after administering an EpiPen even if the student is feeling better.**
2. **Call Parents to Notify them an EpiPen has been given & 911 called.**

If you want additional care given, describe action here:

____

Physician Signature_______________________________________ Print Name:____

Phone:______________________ Date: ________

- I want this plan implemented for my child, ____, in school. I hereby give my permission for the exchange of confidential information contained in the record of my child between the School Nurse and Medical Provider, my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/GuardianSignature:____Date:____________

Attach Student Photo: ******* Attach Medical orders & Allergy Action Plan ******** **Edited 6/12/25 MGW**