

**PLACE  
PICTURE  
HERE**

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

Allergic to: \_\_\_\_\_

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

History of anaphylaxis:  **Yes**  **No**

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

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. **ADMINISTER 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.

**ADDITIONAL PHYSICIAN COMMENTS**

**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 AND CALL 911.**

**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 and call 911.

If this box is checked by the child's physician, the child has an extremely severe allergy to \_\_\_\_\_ and should be given epinephrine at the first sign of any symptoms, even if mild.

**MEDICATIONS/DOSES**

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM (intramuscular)  0.15 mg IM  
 0.3 mg IM  1 mg IN (intranasal)  2 mg IN

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

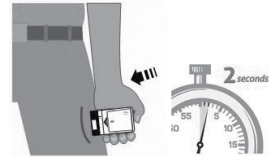
Antihistamine Dose: \_\_\_\_\_

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

Patient may self-carry  Patient may self-administer

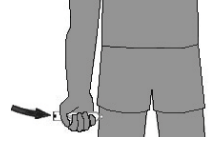
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



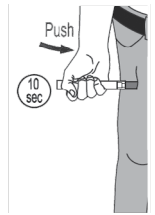
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

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.



## 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.

## HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



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: \_\_\_\_\_

**San Mateo Union High School District**  
**Authorization for Medication(s) to be Taken During School Hours**

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the California Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be take, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.

**With the approval of the pupil's authorized health care provider and the approval of the pupil's parent or legal guardian, a local education agency may allow a pupil to carry medication and to self-administer the medication.**

**THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT:** School Name \_\_\_\_\_

Student Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First

Physician/Health Care Provider's Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_  
( )

**In regards to the medication authorized below by her/his physician/health care provider:**

**I request that my student be assisted in taking the medicine(s) at school by authorized persons:** Yes \_\_\_\_\_ No \_\_\_\_\_

**I request that my student be permitted to carry medication & self-medicate her/himself:** Yes \_\_\_\_\_ No \_\_\_\_\_

I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of the original prescription; strength and dose of medication; and directions for use. If medication is kept at school in the health office, it will be destroyed unless picked up within one week after the end of the school year or end of the medical order. I have read and signed the attached consent (reverse side) to allow designated school personnel to consult with my student's health care provider regarding medication questions. I understand that the medication may be discontinued with written parental request. As parent/guardian of the above-named student, I hereby indemnify and hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of the San Mateo Union High School District who may act pursuant to the instruction of my student's health care provider.

\_\_\_\_\_  
Date Signature of Parent/Guardian Home Phone Emergency  
( ) ( )

**THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:**

Diagnosis for which medication is given: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Form: \_\_\_\_\_ Dose & route: \_\_\_\_\_

If medicine is to be given DAILY, at what time(s): \_\_\_\_\_

If medicine is to be given WHEN NEEDED, describe indications: \_\_\_\_\_

How soon can it be repeated?: \_\_\_\_\_ Length of time this treatment is recommended: \_\_\_\_\_

List significant side effects of medication: \_\_\_\_\_

**In my opinion, this student shows the capability to carry and self-medicate the above medication:** Yes \_\_\_\_\_ No \_\_\_\_\_

**If necessary, this medication may be safely and appropriately administered by trained unlicensed school personnel:** Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Authorized Health Care Provider: \_\_\_\_\_

Health Care Provider  
Address Stamp (required):

**SAN MATEO UNION HIGH SCHOOL DISTRICT**  
**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services at school.

**USE AND DISCLOSURE INFORMATION:**

Patient/Student Name: \_\_\_\_\_  
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) \_\_\_\_\_ (2) \_\_\_\_\_

to provide health information from the above-named student's medical record to and from:

<b><u>San Mateo Union High School District</u></b> School District to which disclosure is made	<b><u>650 North Delaware St., San Mateo, CA 94401</u></b> Address/City and State/Zip Code
<b><u>Sara Devaney, Health Services Manager</u></b> Contact person at School District	<b><u>650-558-2222 (Confidential Fax 650-762-0250)</u></b> Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following:  All health information; or  Disease-specific information as described:

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for one year from the date of signature, if no date entered.

**RESTRICTIONS:** California law prohibits the School District from making further disclosure of my health information unless the School District obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that the School District will protect this information as prescribed by the Family Educational Rights Privacy Act (FERPA) and state law and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. *If you move to another School District, records will be transferred automatically to that School District.*

**YOUR RIGHTS:** I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the School District or others have acted in reliance to this Authorization.*

**APPROVAL:** \_\_\_\_\_  
Printed Name Signature Date  
\_\_\_\_\_  
Relationship to Patient/Student Area Code and Telephone Number