ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/ St. Mary's County Health Department

ALLERGY EMERGENCY ACTION PLAN
PARENT(S)/LEGAL GUARDIAN(S) AND PHYSICIAN/PRESCRIBER AUTHORIZATION - MEDICATION ORDERS

This order is valid for school year _____ including the summer session Teacher: _____ Grade: _____

Name of Student: _____ DOB: _____ Weight: _____ lbs.

Allergy to: _____

Asthma: ☐ Yes (higher risk for anaphylaxis) ☐ No

Student's Photo

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year for each medication, and each time there is a change in dosage, type, time, and route administration of a medication.

- ❖ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ❖ Non-prescription medication must be in the original container with the label intact.
- ❖ An adult must bring the medication to the school.
- ❖ The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

IMPORTANT REMINDER: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

1) Any SEVERE SYMPTOMS after suspected or known ingestion: **One** or **more** of the following:
LUNG: Short of breath, wheeze, repetitive cough, noisy, or difficulty breathing
HEART: Pale, blue, faint, weak pulse, dizzy, loss of consciousness
THROAT: Tight, hoarse, trouble breathing or swallowing, swelling of throat
MOUTH: Obstructive swelling (tongue and/or lips)
Or combination of symptoms:
SKIN: Hives, generalized itching, tingling, and/or swelling (e.g., eyes, lips), generalized flushing
GI: Nausea, vomiting, diarrhea, cramping
MENTAL: Uneasiness, agitation, panic, feeling of impending doom
2) KNOWN INGESTION and PREVIOUS HISTORY OF ANAPHYLAXIS to the allergen (no symptoms need to be present)

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Stay with student, begin monitoring
4. Give a second dose of epinephrine (if available) if symptoms get worse.
5. Give additional medications if prescribed:*
   - Antihistamine
   - Inhaler (bronchodilator) if asthma symptoms present

* Antihistamines and inhalers or bronchodilators are not to be depended upon to treat or prevent a severe reaction (anaphylaxis)

Emergency Action Steps – DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one): ☐ Adrenaclick (0.15 mg) ☐ Adrenaclick (0.3 mg) ☐ Auvi-Q (0.15 mg) ☐ Auvi-Q (0.3mg) ☐ EpiPen Jr. (0.15 mg) ☐ EpiPen (0.3 mg)

Specify other(s): _____

Prescriber's Authorization

Medication Name: _____ Dose: _____ Route: _____

PRN & Frequency: ☐ May give 2nd injection if needed, for what symptoms?: _____

Relevant Side Effects: ☐ None Expected ☐ Specify: _____

Other Medication(s) Name: _____ Dose: _____ Route: _____

PRN: _____ Frequency: _____ For what symptoms?: _____

Relevant Side Effects: ☐ None Expected ☐ Specify: _____

ALLERGY EMERGENCY ACTION PLAN
PARENT(S)/LEGAL GUARDIAN(S) AND PHYSICIAN/PRESCRIBER AUTHORIZATION - MEDICATION ORDERS (CONTINUED)

Prescriber's Name/Title: _____
(Type or Print)

Office #: _____ FAX #: _____

Address: _____

_____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN/LPN (Name): _____ for the above medication on (Date): _____.

Self Carry/Self Administration of Emergency Medication Authorization/Approval

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication administration policy.

_____ It has been determined this student is able to self-administer and carry emergency medication and
Prescriber's Initials has been trained in its use.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school nurse: _____
Signature Date

Note: A non-nursing person may administer medication(s). If possible, arrange time of dosage so that medication(s) will not have to be given while the child is in school. School hours vary with each school.

******This section to be completed by the parent(s)/legal guardian(s)******

Emergency Response Information

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

Parent/Legal Guardian #1: _____ Parent/Legal Guardian #2: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Name of Student: _____

I/We request designated school personnel to administer the medication as prescribed by the prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that it is my/our responsibility to furnish this medication. I/We further understand that any school employee who administers any drug to my/our child, in accordance with written instructions from the prescriber and St. Mary's County Public Schools, shall not be liable for damages as a result of an adverse drug reaction suffered by my/our child due to the administration of the drug. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent(s)'/Legal Guardian(s)' Signature: _____ Date: _____

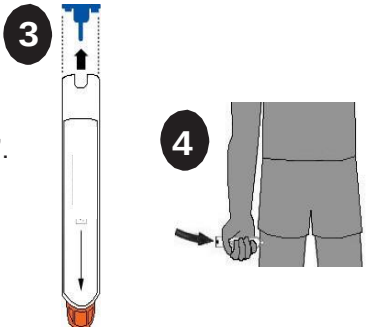
Note: When this form is complete and signed by the physician and parent(s)/legal guardian(s), return it to the school nurse at your child's school along with the prescribed medication in the original pharmacy container. Thank you.

Trained Staff Members

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____
4. _____ Room _____
5. _____ Room _____
6. _____ Room _____

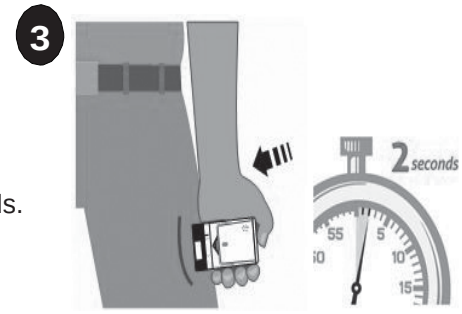
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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 AUVI-Q® (EPINEPRHINE 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.



Reviewed by: _____ Title: _____ Date: _____

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