MAYNARD
PUBLIC SCHOOLS

MEDICATION ADMINISTRATION FOR STUDENT WITH SEVERE ALLERGY

SCHOOL YEAR _____

STUDENT _____ **BIRTH DATE**_____ **TEACHER**_____

➔ ➔ ➔ ➔ ➔ **TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER** ← ← ← ← ←

ALLERGY DOCUMENTED BY: ❑ Prior Reaction – date/describe: _____
❑ Allergy Testing – date/describe: _____
❑ Other: _____

TYPE OF EXPOSURE RISK: ❑ Ingestion ❑ Skin Contact ❑ Inhalation ❑ Other

DOSAGES: Epinephrine – auto-inject IM (circle one): EpiPen (0.3mg) EpiPen Jr (0.15mg)
Antihistamine – medication/dose/route: _____
Other Treatment or medication/dose/route: _____

PRESCRIBED TREATMENT: ADMINISTER CHECKED MEDICATION **STAT**

If exposure/ingestion of allergen but ***no immediate symptoms:*** ❑ EpiPen Jr ❑ EpiPen ❑ Antihistamine

If exposure/ingestion of allergen ***with symptoms:*** ❑ EpiPen Jr ❑ EpiPen ❑ Antihistamine

Other: _____

Symptoms *may* include: itching, tingling, swelling, tightening of throat, shortness of breath, wheezing, coughing, hives, nausea, vomiting, diarrhea, low BP, cyanosis, fainting.

➔ ➔ ➔ **If EpiPen is administered, EMS (911) will be summoned for transport to nearest ER**. ← ← ←
Student will be placed in supine position with legs raised until arrival of ambulance.

❑ EpiPen shall be kept in the School Nurse's Office except during field trips.

❑ A second EpiPen may be kept in the student's classroom.

❑ This student must carry an EpiPen with him/her at all times. He/she is capable and responsible for self-administration but must notify staff immediately if used.

Physician/Licensed Prescriber Signature: _____ Date: _____

Stamp or Print Physician's Name: _____

Address: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____