MAYNARD
PUBLIC SCHOOLS

MEDICATION ADMINISTRATION FOR STUDENT WITH SEVERE ALLERGY

To Be Completed By Physician and Parent

SCHOOL YEAR ______________________

STUDENT ___________________________________ **BIRTH DATE**___________ **TEACHER**______________

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

DIAGNOSIS/ALLERGIC TO: ____

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: ____________