

EPI PEN ADMINISTRATION and CARE PLAN

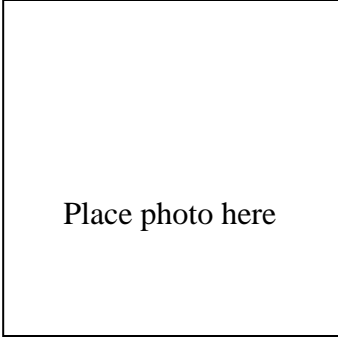
Manhattan Beach Unified School District School _____
 School Year _____ Health Office x _____ Office x _____

STUDENT NAME: _____ **DOB:** _____ **Grade/Room** _____ / _____

DIAGNOSIS (specify) _____
ALLERGENS (specify) _____
SEVERE _____

MILD _____

Has Epi Pen been used? NO ___ YES ___ AGE _____



Medication Orders

Name and form of medication	Dosage prescribed	Indication / schedule
ANTI-HISTAMINE/ Benadryl or _____	_____ ml liquid or perfect measure 12.5mg/5ml _____ thin strips 12.5 mg/strip _____ chewable tablets, 12.5mg/tablet _____ 25 mg/capsule/tablet	
EPI PEN	_____ Epi Pen (.3mg) _____ Epi Pen JR (.15mg) _____ Auvi- Q (.3 mg) _____ Auvi-Q JR (.15 mg)	

Special Instructions: _____

MILD REACTION: hives, itching, sneezing, swelling of the face or extremities or if the allergen has been ingested but no symptoms

What to do:

- Administer **Antihistamine**
- Call Parent to take home for further observation / Monitor for progression of signs to severe reaction

SEVERE REACTION: DIFFICULTY BREATHING OR SWALLOWING severe symptoms may include: itching, tingling or swelling of the lips, tongue, or throat, nausea, abdominal cramps, vomiting, diarrhea, tightening of throat, hoarseness, coughing, wheezing, nasal flaring, shortness of breath

What to do:

- **SUMMON HELP, ADMINISTER EPI PEN**
- **ADMINISTER BENADRYL** and / or **PREDNISONE** (if not already given and student can swallow)
- **CALL 911** Parent, Principal, District Nurse
- **ONE PERSON STAY WITH STUDENT**

PARENT STATEMENT:

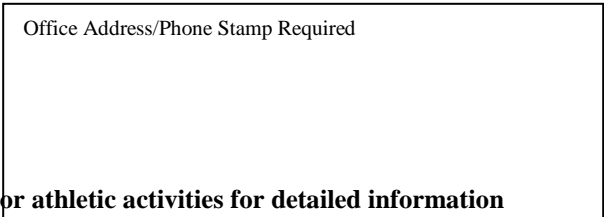
- I hereby request that a school employee store and administer the medication(s) named above per the physician's order
- My child (grade 9 and above or under special circumstances agreed upon with district nurse) may carry and is trained to self administer the above medication without adult supervision. I understand and accept that no direct monitoring will be conducted by the school staff. I understand that it is strongly encouraged to have back up medication stored in the school health office.

I agree to provide the medication(s) named above and replacement medication(s) in container(s) labeled by the pharmacy and a change of label if dosage is changed; a new authorization for new medication(s) or changes in the dosage of the medications listed. I understand that it is the Parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician or medication occurs. I give my consent for the district nurse to communicate with the physician and to counsel with school personnel regarding my child.

Parent Name _____ home phone _____ work/cell _____
 Emergency Contact _____ home phone _____ work/cell _____

Parent Signature **Date**

Physician Signature **Date**



Contact the District Nurse at least two weeks prior to off campus field trips or athletic activities for detailed information regarding medication administration.