EPI PEN ADMINISTRATION and CARE PLAN

Manhattan Beach Unified School District School _____

School Year _____ Health Office x_____ Office x_____

STUDENT NAME: _____DOB:_____ Grade/Room____ /____

Place photo here

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
ANTIHISTAMINE/ 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**

Office Address/Phone Stamp Required

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