

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [] Yes (higher risk for a severe reaction) [] No

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Short of breath,
wheezing,
repetitive cough



HEART

Pale, blue,
faint, weak
pulse, dizzy



THROAT

Tight, hoarse,
trouble
breathing/
swallowing



MOUTH

Significant
swelling of the
tongue and/or lips



SKIN

Many hives over
body, widespread
redness



GUT

Repetitive
vomiting, severe
diarrhea



OTHER

Feeling
something bad is
about to happen,
anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy/runny
nose,
sneezing



MOUTH

Itchy mouth



SKIN

A few hives,
mild itch



GUT

Mild nausea/
discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [] 0.15 mg IM [] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

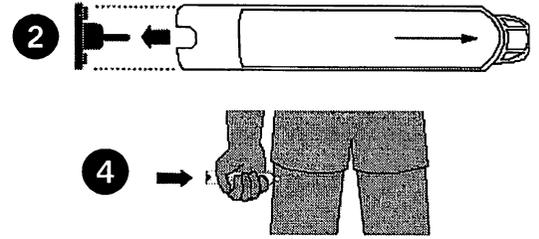
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



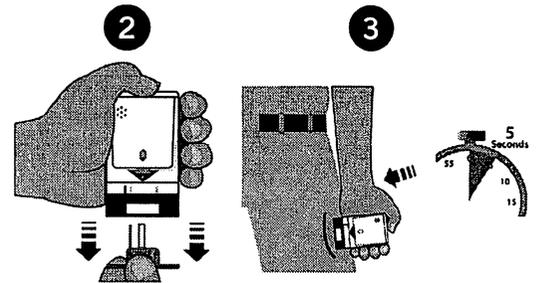
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

ARCHDIOCESE OF ATLANTA

MEDICATION PERMIT FORM

All medication should be given outside of school hours if possible. Three-times-a-day medications should be given before school, after school and at bedtime for optimal coverage. If necessary, medication can be given at school only under the following conditions:

- 1. If medication is needed in order for the student to remain in school, this form must be completed by the parent/guardian, signed by the physician, and returned with the medication to the school office or nurse.
2. All necessary medication prescribed for a student by a doctor or dentist must have this Medication Permit Form signed by the physician and parent. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label.
3. The parent is responsible to bring all medication to the clinic/office and to pick up unused medicine or it will be destroyed.
4. Experimental medication/dosages will not be given. Herbal medication, dietary supplements and other nutritional aids not approved as medication by the FDA, will not be administered at school.
5. Antibiotics will not be given at school by school personnel. If the parent feels the antibiotic must be given during the school day, the parent may come to the school office/clinic and administer it.
6. All medications must be kept in a locked cabinet/drawer in the school office/clinic and administered in the school office/clinic.
7. High School students whose doctor's written instructions require them to carry an inhaler on their person may do so. A second inhaler must also be kept in the clinic for use as needed.
8. Only the parent or adult designee perform nebulizer treatments in school.

TO THE NURSE OR HEALTH REPRESENTATIVE OF: ST. PIUS X CATHOLIC HIGH SCHOOL

NAME OF STUDENT: GRADE: ROOM:

NAME OF MEDICATION:

DOSAGE AND DIRECTIONS FOR GIVING:

BEGINNING DATE: ENDING DATE:

I hereby request that the medication specified above be given to the above named student, and that the medication may be given by someone other than a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein.

SIGNATURE OF PARENT/GUARDIAN: DATE:

SIGNATURE OF PHYSICIAN: DATE: (STAMPED SIGNATURE NOT ACCEPTED)

PHYSICIAN'S TELEPHONE NUMBER:

MEDICAL AGREEMENT WITH _____ CATHOLIC
SCHOOL FOR STUDENT TO CARRY AND SELF-MEDICATE PRESCRIBED
MEDICATION

I, _____, as the parent of _____,
Parent/Legal Guardian *Student Legal Name*

who is a student at _____ Catholic School, will follow the guidelines set forth below, in order for the student to carry his/her own medication on campus.

- I will submit a letter from the physician in which he/she states that the above named child is capable and knowledgeable of self-medicating procedures. The letter further states that it is a medical necessity for the above named student to carry his/her medication on campus.
- I will submit the Archdiocese of Atlanta Medication Permit Form, signed by me and my child's physician.
- I will be responsible to supply the nurse with a duplicate medication to be kept in the clinic.
- My child and I will meet with the Administration and the school nurse to have my child demonstrate his/her competence in self-administration of his/her medication. If the school nurse believes the student is too young or does not show sufficient understanding of how and when to self-medicate, the student will not be allowed to carry the medication on campus.
- I will educate my child to report immediately to the clinic after self-administration. The school nurse will activate emergency medical procedures by calling 911 and will log the incident.
- I will educate my child to the fact that no other student should ever have possession of his/her medication/medication bag.
- I will educate my child that the abuse of this medication on campus will preclude the child from further being able to carry said medication on campus.
- The school will revoke the permission for said child to carry his/her medication due to any misuse of the prescription medication on campus.

The medication to be carried is _____, and it will
be carried in _____.

I, _____, as parent/guardian of _____,
Parent/Legal Guardian *Student Legal Name*

take full responsibility for the actions of my child as a result of carrying this medication and assume all liability regarding said child and the carrying of his/her prescription medication on campus.

<i>Parent/Legal Guardian</i>	<i>Date</i>	<i>Student Signature</i>	<i>Date</i>
<i>School Administrator</i>	<i>Date</i>	<i>Nurse</i>	<i>Date</i>