

MEDICATION ORDER TO CARRY EPI PEN

***INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT
TO CARRY PRESCRIBED EPI FOR SEVERE ALLERGIC REACTIONS***

*(Use medication Order to Carry Asthma Inhaler for asthma treatment.
Medication Order to Carry for other medications.)*

Online forms: <http://sbo.nn.k12.va.us/healthservices/medications.html>

These requests are exceptions to School Board Policy JLCD and must be approved.

1. ***Parents will submit the following forms (all forms must be in order and signed):***
 - a. ***Request for Approval for Students to Carry Prescribed Medication***
 - b. ***LAMP Part 1*** (completed by parent)
 - c. ***LAMP Part 2 and Part 3*** (signed by the medical provider, parent and student)
 - d. ***Responsibilities of Students and Parent Requesting Exception to Rule 3 (MEDICATION) and Rule 26 (ALCOHOL AND OTHER DRUGS)***
(completed and signed by parent and student)
2. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*
3. *The school nurse will complete an Emergency Care Health Plan. (see LAMP)*
4. *The Registered Nurse (School Nurse) will review the request and contact the prescribing physician if indicated.*
5. *The Health Services supervisor and the school medical advisor will be contacted if there are any questions about approval.*
6. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*
7. *The parents will sign a form assuming full responsibility and releasing the school of liability.*
8. *The school's registered nurse and principal will sign approving the request.*
9. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*



Health Services

12465 Warwick Boulevard, Newport News, VA 23606-3041 ■ phone: 757-591-4646 ■ fax: 757-595-2017

**REQUEST FOR APPROVAL FOR STUDENT TO CARRY
PRESCRIBED MEDICATION**

This form is to be completed by the parent. The physician must complete the appropriate medication order. (Please use the appropriate request: Asthma for inhalers, Epi pen for severe allergies, or other medications)

Name of Student: _____ Birth Date: _____

Home Address: _____

Name of Parent(s): _____

Medication to be carried: _____

Reason student needs to carry: _____

Additional information: _____

*I request my son/daughter to carry the above-prescribed medication. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. **A medical provider has completed the necessary parts of this packet and agrees that my child needs to carry this medication and understands how to use it.** I understand this request is for the current school year only.*

Parent's Signature

Date

Attached and completed: (All must be reviewed by RN)

___ Signed order from Medical Provider that student is trained and able to carry

___ Parent signature to request

___ Exception to Rule 3 & 26 (parent and student signed)

___ Medical Release of Liability

Notes: _____

Approved for current school year:

_____, RN
School Nurse

Date

Principal
R-4/15

Date

Hampton Roads Regional Schools Life-Threatening Allergy Management Protocol Forms

Developed by the Hampton Roads School Nurse Managers

Parents/Guardians: Please complete Life Threatening Allergy Management Plan (LAMP) Part 1 (both sides) and Part 3 if applicable. Part 2 must be completed by your medical provider and Part 3 if applicable. Return to the School Nurse.

Please contact the School Nurse to review the entire protocol and develop appropriate precautions and emergency measures.

Protocol Statement

The incidence of life threatening allergies has been on the rise over the past 15-20 years. School districts should expect to serve students with these life-threatening allergies during the school year. School staff must be prepared to deal with students with life-threatening allergies, recognize the potential for anaphylaxis, and provide emergency care in the event of an allergic reaction.

This protocol was written to assist school personnel in implementing preventive as well as emergency measures. These plans can save the life of a child by preparing school staff to manage the care of a student with life-threatening allergies. Students can be affected by many allergens; however, the most common life-threatening types are food, insect venom, and latex. While it is important to prevent exposure to allergens, they cannot be totally eliminated from schools.

Communication is the vital link in presenting and implementing this protocol. Education, cooperation and awareness are keys to keeping children with life threatening allergies safe. Parent, student, physician and school staff need to work together to determine appropriate precautions and procedures to develop an individualized plan of action for managing each student at school.

Newport News Public Schools Medical Advisor and the Allergy/Immunization Department at CHKD agree that any student given epinephrine should be transported by 911 to the hospital.

Responsibilities

A. Parent/Guardian Responsibilities

- Inform the school nurse/school administrator of your child's allergies before school starts or as soon as the diagnosis is made.
- Provide written medical documentation, instructions, and medications, as directed by a physician, to the school nurse each school year. **All food allergies must be verified by documentation from a physician, nurse practitioner or physician assistant.**
- Provide properly labeled medications each school year and replace medications after use or upon expiration.
- If stock epinephrine is used for a student that has a known allergy and the parents/guardian has not provided the epi pen ordered by their medical provider, the parent/guardian will have to pay the restock price to NNPS. The student can be medically excluded until the parent/guardian provides the ordered epi pen and/or medical instructions.
- Work with the school team to develop an individual plan that accommodates the child during school.
- Provide age appropriate education to your child in the self- management of his/her allergies. It is important that students take more responsibility for their food allergies as they grow older and are developmentally ready to accept responsibility. (Refer to III-B Student Responsibilities)
- Provide accurate emergency contact information and update as necessary.
- Notify the school nurse or designee of any change in your child's allergy status or if any reaction occurs outside of school.
- Provide all supplies and equipment necessary for implementing your child's *Life- Threatening Allergy Management Plan (LAMP)*. Replenish supplies as needed.
- Consider a medical alert bracelet for your child.
- Review Checklist for Parents (Appendix B).

B. Student Responsibilities

- Learn to recognize symptoms of an allergic reaction and **notify school staff immediately** if a reaction is suspected or they believe they may have come in contact with their allergen.
- Take as much responsibility as possible to prevent an exposure to allergens based on their developmental level.
- Do not trade or share food with others.
- Understand the care and management of their allergies and reactions based on their developmental level.
- Wash hands before and after eating food/snacks.
- Know where the Epi-pen /Twinject is located and who has access to medication.
- Report teasing, bullying and threats to school personnel.
- Understand school policy and procedure to self-carry epinephrine auto-injector, if appropriate.
- Self-advocate in situations that they perceive as compromising their health.

Life-Threatening Allergy Management Plan (LAMP)

Student:	School:	Effective Date:
Date of Birth:	Grade:	Homeroom Teacher:

Dear Parent/Guardian: please provide the information requested below to help us care for your child at school.

Part 1- Medical history and contact information. To be completed by parent/guardian.

Part 2- Have your child’s physician complete this section unless the physician’s office prefers to use his/her own Life Threatening Allergy Management Plan which must include all components.

Please note: A physician’s order must be submitted to the school nurse at the beginning of each school year and whenever modifications are made to this plan.

Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

PART 1—TO BE COMPLETED BY PARENT/GUARDIAN		
Contact Information:		
Parent/Guardian #1:		
Address:		
Telephone-Home:	Work:	Cell:
Parent/Guardian #2:		
Address:		
Telephone-Home:	Work:	Cell:
Other emergency contact:		
Address:		Relationship:
Telephone-Home:	Work:	Cell:
Physician treating severe allergy:		Office #:
Please answer the following questions:		
1. What is your child allergic to?		
2. What age was your child when diagnosed?		
3. Has your child ever had a life-threatening reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. What is your child’s typical allergic reaction?		
5. Does your child have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Does your child know what food/allergens to avoid? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Does your child recognize symptoms of his/her allergic reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Will you be providing meals and snacks for your child at school? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Will your child always eat the school provided breakfast and/or lunch? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. How does your child travel to school? <input type="checkbox"/> Bus # _____ <input type="checkbox"/> Car <input type="checkbox"/> Walk		

Life-Threatening Allergy Management Plan (LAMP)

I give permission to the school nurse and designated school personnel, who have been trained and are under the supervision of the school nurse of _____ School, to perform and carry out the severe allergy tasks as outlined in _____ (Child's name) Life Threatening Allergy Management Plan (LAMP) as ordered by the physician. I understand that I am to provide all supplies necessary for the treatment of my child's severe allergy at school. If stock epinephrine is used for a student that has a known allergy and the parents/guardian has not provided the epi pen ordered by their medical provider, the parent/guardian will have to pay the restock price to NNPS. The student can be medically excluded until the parent/guardian provides the ordered epi pen and/or medical instructions. I also consent to the release of information contained in the LAMP to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above named physician regarding my child's severe allergy.

Parent's Name	
Parent 's Signature	Date
School Nurse's Name	
School Nurse's Signature	Date

Every effort possible will be made to keep your child away from the stated allergen. However, this does not guarantee that your child will never come into contact with the stated allergen in the school setting.

Whenever epinephrine is given at school, 911 is called and the student transported to the hospital (see #4 on following page).

Life-Threatening Allergy Management Plan

To be completed by MD: Valid for Current School Year _____

Name: _____ DOB: _____ Weight _____

Allergy to: _____

Asthma: Yes (high risk for severe reaction) No See Asthma Action Plan

Extremely Reactive to: _____

If known exposure, give epinephrine immediately and call 911.

Action for Mild Reaction:

Systems:

Mouth:

Skin:

Gut:

Symptoms:

itchy mouth

minor itching "and/or" a few hives

mild nausea/discomfort



Liquid

diphenhydramine (12.5mg/5ml) p.o.
(can be repeated q 4-6 hours)

cetirizine (5mg/5ml) p.o.
(do not repeat)

Dose: _____

Stay with student. Alert parent. If symptoms worsen then follow steps for major reaction.

Action for a Major Reaction: (two systems or single severe symptom)

Systems:

MOOUTH

THROAT

LUNG

HEART

SKIN

GUT

Symptoms:

swelling of the lips, tongue, or mouth

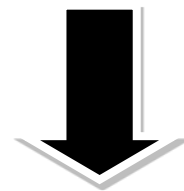
tight throat, hoarseness, drooling, trouble swallowing

shortness of breath, repetitive cough and/or wheezing

thready pulse, faint, confused, dizzy, pale, blue

multiple hives, swelling about the face and neck

abdominal cramps, vomiting



1. Inject Epinephrine immediately intramuscularly

Epipen® Epipen® Jr Auvi-Q™ 0.30mg Auvi-Q™ 0.15mg _____

2. Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT

- Students should not suddenly sit up, stand or be placed in the upright position. This increases risk for sudden death.

3. Note time epinephrine was given and repeat dose after 5 minutes if no improvement or worsening symptoms.

- Antihistamines and inhalers are not first line therapy in a severe reaction.

4. Transport via EMS to the emergency department.

Emergency Contacts:

Parent/Guardian _____ Phone: _____

Other emergency contact _____ Phone: _____

Parents Signature

DATE

DOCTOR'S SIGNATURE

DATE

Print MD Name:

School Nurse's Signature

DATE

Contact number:

Life-Threatening Allergy Management Plan (LAMP)

Permission to Carry and/or Self-Administer Epinephrine (if appropriate)

Name: _____ DOB: _____

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and self-administering this medication(s). The nurse or the appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

- Self-Carry
- Self-Administer

Healthcare Provider Signature

Print Healthcare Provider Name

Date

In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the school board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student's possession and/or self-administration of said emergency medication relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

Parent/Guardian Signature

Date

Student Signature

Date

**RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO
RULE 3 (MEDICATION) AND RULE 26 (ALCOHOL AND OTHER DRUGS)**

(Request to Carry Prescribed Medication on One's Person)

I request my son/daughter _____ carry the following
prescribed medication: _____.

I have read Rule 3 (Medication) and Rule 26 (Alcohol and Other Drugs) which state:

Rule 3. Medication: A student must take all medication (prescribed or over-the-counter drugs) in the clinic.

Rule 26. Alcohol and Other Drugs: Except as permitted under Rule 3 (Medications), a student shall not use, purchase, sell, distribute, be under the influence of or possess any kind of alcoholic beverage or any kind of controlled substance as defined by state law. This prohibition includes, but is not limited to, anabolic steroids, substances that look like drugs, imitation controlled substances, and drug paraphernalia. For example:

E. Possession/Attempt – Possessing, or attempting to possess, any illegal or controlled substance; any action that contributes to the possession of any illegal or controlled substance.

F. Sale/Distribution/Purchase/Attempt – Distributing, selling or purchasing any illegal or controlled substance; attempting to sell, distribute, or purchase any illegal or controlled substance; or any action that contributes to the possession of any illegal or controlled substance.

I understand that approval of this request does not release my son/daughter from penalty if he/she misuses this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will be the same as Rule 26 E or H.
Level 7 Expulsion

I have read, reviewed and explained this information to my son/daughter. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Signed _____ (Parent) Date: _____

Signed _____ (Student) Date: _____