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.)
For online forms: [http://sbo.nn.k12.va.us/healthservices/medications.html](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. [V. Part 1 front and back](#) (completed by parent)
   c. [Part 2 and Part 3](#) (signed by the medical provider, parent and student)
   d. [Responsibilities of Student 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 Health Services supervisor will be contacted and review the papers.

5. The school medical advisor will contact the prescribing physician if necessary.

6. Parents of students who will self-administer epinephrine **must** contact the school nurse. The school nurse will discuss as necessary with the principal, parent, student, teachers, and other school personnel safety precautions regarding students who carry prescribed medication. As indicated, students who carry any medication will demonstrate how to safely administer it.

7. The parents will sign a form assuming full responsibility and releasing the school of liability.

8. The school medical advisor, health services supervisor, 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 Manual: Medications R-6/12*
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)

For online forms:  http://sbo.nn.k12.va.us/healthservices/medications.html

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

Approval by:

_________________________________________  ________________________
Newport News Public Schools’ Medical Advisor  Date

_________________________________________  ________________________
Health Services Supervisor     Date

_________________________________________  ________________________
Principal        Date

R-6/12
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

<table>
<thead>
<tr>
<th>Contact Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parent/Guardian #1:</strong></td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Telephone-Home: Work: Cell:</td>
</tr>
<tr>
<td><strong>Parent/Guardian #2:</strong></td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Telephone-Home: Work: Cell:</td>
</tr>
<tr>
<td><strong>Other emergency contact:</strong></td>
</tr>
<tr>
<td>Address: Relationship:</td>
</tr>
<tr>
<td>Telephone-Home: Work: Cell:</td>
</tr>
<tr>
<td><strong>Physician treating severe allergy:</strong></td>
</tr>
<tr>
<td>Office #:</td>
</tr>
</tbody>
</table>

**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?  
   - Yes  
   - No  
4. What is your child’s typical allergic reaction?  
5. Does your child have asthma?  
   - Yes  
   - No  
6. Does your child know what food/allergens to avoid?  
   - Yes  
   - No  
7. Does your child recognize symptoms of his/her allergic reaction?  
   - Yes  
   - No  
8. Will you be providing meals and snacks for your child at school?  
   - Yes  
   - No  
9. Will your child always eat the school provided breakfast and/or lunch?  
   - Yes  
   - No  
10. How does your child travel to school?  
    - Bus #  
    - Car  
    - Walk
# Part 2: Life-Threatening Allergy Management Plan (LAMP)

To Be Completed By Health Care Provider  
Valid for Current School Year _____________

Name: ___________________________________ DOB: ___________________

Allergy to: _____________________________

Asthma: □ Yes* □ No *High risk for severe reaction □ yes □ no □ Asthma Action Plan

It is medically necessary for student to carry epinephrine during school hours □ Yes □ No

## Signs of an Allergic Reaction Include:

<table>
<thead>
<tr>
<th>Systems</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOUTH</td>
<td>Itching and swelling of the lips tongue or mouth</td>
</tr>
<tr>
<td>THROAT</td>
<td>Itching and or a sense of tightness in the throat, hoarseness and hacking cough</td>
</tr>
<tr>
<td>SKIN</td>
<td>Hives, itchy rash and/or swelling about the face or extremities</td>
</tr>
<tr>
<td>GUT</td>
<td>Nausea, abdominal cramps, vomiting, and/or diarrhea</td>
</tr>
<tr>
<td>LUNG</td>
<td>Shortness of breath, repetitive cough and/or wheezing</td>
</tr>
<tr>
<td>HEART</td>
<td>“thready pulse”, “passing-out”</td>
</tr>
</tbody>
</table>

*the severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation*

## Action for a Minor Reaction:

1. If ingestion is suspected and/or symptom(s) are: minor itching “and/or” mild hives to skin give:

   **Liquid Benadryl (or generic dephenhydramine)**

   Dose: ___________________

   by mouth now and every 4-6 hours as needed.

2. Call Mother at __________________ Father at _______________ or emergency contact.
3. Call Dr. __________ at ___________________ to make physician aware of child’s reaction.

If condition worsens or does not improve within 10 minutes follow steps for MAJOR Reaction below:

## Action for a Major Reaction:

1. If symptom(s) are large amount of hives, throat swelling, cough, difficulty breathing, wheezing, vomiting, diarrhea or if symptoms progress after Benadryl is given, give:

   □ -Epinephrine: inject intramuscularly: (check below)

   □ Epipen® □ Epipen® Jr □ Twinject ™ 0.3mg □ Twinject ™ 0.15mg

   □ -Liquid Benadryl: dose: _____________ every 4-6 hours as needed (if able to tolerate liquids)

   □ -Albuterol /or quick relief inhaler: 2 puffs with spacer now (IF asthmatic)

   **Give above now then call:**

   2. Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT

   3. Repeat dose of Epinephrine if no improvement in 5-10 minutes

   4. Call Mother at ________________ Father at ________________ or emergency contact.

   5. Call Dr. ______________ at ______________ to make physician aware of child’s reaction.

PARENTS SIGNATURE: ___________________ DATE: ______________

DOCTOR’S SIGNATURE: ___________________ DATE: ______________

Print MD Name: __________________________

Address: _______________________________
Part 3: 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
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. 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.

<table>
<thead>
<tr>
<th>Parent’s Name</th>
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<tbody>
<tr>
<td>Parent’s Signature</td>
<td>Date</td>
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</table>

<table>
<thead>
<tr>
<th>School Nurse’s Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>School Nurse’s Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

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.
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 or any action that contributes to the possession of any illegal or controlled substance.

H. 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: ________________

R-6/12
MEDICATION RELEASE OF LIABILITY FORM

Student: ___________________________ School: ___________________________ Grade: ______

Address: ____________________________________________________________________________

Parent/Guardian: ___________________________ Phone: # ___________________________

Phone # ___________________________ (Home)

Phone # ___________________________ (Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of ____________________________________________________________________________

I hereby request and authorize you to assist and/or give

____________________________________________________________________________________

(Dose and Medication)

to: ____________________________________________, as prescribed by

(Student’s Name)

____________________________________________________________________________________

(Doctor’s Name)

I release school personnel from liability should reactions result from this medication, whether self-administered by my child or given by

school personnel. If possible, I prefer follow-up care and transportation as follows:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Parent/Guardian Signature ___________________________ Date ___________________________

R-1/12