EMERGENCY HEALTH CARE PLAN

EPI-PEN® ADMINISTRATION **Date**_____

Dear Parent/Guardian: The following is an emergency health care plan for your child, who has an EpiPen® prescribed for her/him. Please complete the parent/guardian section and forward this form to your child's physician and request that it be returned to the school nurse right away. Thank you,

_____,School Nurse **Phone: 617-_____**

Fax: 617-_____

THIS SECTION BELOW TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name_____Gr/Class_____

Asthma: ___Yes ___No School_____ **(PHOTO HERE)**

Allergy to_____

_____

Signs and Symptoms of Previous Allergic Reactions:_____

_____

Permission to <u>administer</u> / <u>self-administer and carry</u> prescribed medications:_____

(CIRCLE appropriate choice) **(Parent/Guardian SIGNATURE)**

Name_____ Home #_____

Work #_____Cell Phone #_____

Name_____ Home #_____

Work #_____Cell Phone #_____

Other Emergency Contact Information:

Name_____Work #_____ Home #_____Cell#_____

Name_____Work#_____ Home#_____Cell#_____

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THIS SECTION BELOW TO BE COMPLETED BY A PHYSICIAN

1. Use of EpiPen®: Dose_____EpiPen® 0.3 mg _____EpiPen Jr.® 0.15mg

☐ **EpiPen® should be used immediately after a bee/wasp sting, after food ingestion or exposure, or_____, even if the symptoms are mild. CALL 911.**

or

☐ **EpiPen® should be used if the symptoms and signs are progressing to a severe allergic reaction. These may include one or more of the following: rapidly progressing hives or hives all over the body, swelling, choking, hoarseness, cough, wheezing, respiratory distress, fainting, dizziness, vomiting, diarrhea, abdominal pain, or these signs or symptoms:_____ _____. CALL 911.**

Please note: Antihistamines, unlike EpiPens, may be given only when a school nurse is present for assessment and may not be given by non-medical staff members, including on field trips.

2. Additional Comments / Instructions:

3. Name of Physician_____Date_____

Address:_____Phone Number:_____

Signature:_____

Name of Student_____

FOR SCHOOL NURSE TO COMPLETE

1. Medication Information:

A. Storage/Location:

B. Self Administration: _____yes _____no

Comments:

2. Trained Staff Members:

Name	Position	Date of Training	Date of Re-training

*

Comments:

3. Cafeteria Practices:

A. Separate Table: _____yes _____no

B. Other Plan:

4. Plan for classroom/school events which involve food:

5. Other Information: