* Please return with an EpiPen / Auvi-Q that does not expire before 6/16 *

(1)

WAYLAND PUBLIC SCHOOLS

2015 - 2016

MEDICATION ORDER

FOR TREATMENT OF ANAPHYLAXIS USING EPINEPHRINE AND/OR BENADRYL

(Must be completed by a licensed prescriber)

Student:_____ **DOB:**_____ **Sex:**_____

Address:_____

The above named student has a hypersensitivity to:_____

This student is at risk for an anaphylactic reaction. Epinephrine via Epi-pen should be available for treatment. Benadryl given as ordered.

Administer Epi-pen (0.3mg) _____ **Administer Epi-pen Jr. (0.15mg)** _____

Benadryl: Dose_____ **Route**_____ **Frequency**_____

Symptoms_____

TREATMENT PROTOCOL: (Select ONE OPTION only Please)
If an exposure occurs or is suspected to have occurred begin treatment immediately:

( ) **Epinephrine should be administered immediately following exposure regardless of symptoms.**

( ) **Epinephrine should be administered if the student develops symptoms suggesting a generalized reaction as described below:**

- **shortness of breath, wheezing, any difficulty breathing**
- **cough**
- **rash, hives**
- **itching**
- **swelling of lips, tongue, mouth**
- **general flushing**
- **nausea, vomiting abdominal cramps, diarrhea**
- **anxiety**
- **other symptoms, specific to this student:**_____

_____ _____

Signature of Licensed Prescriber **Date**

_____

Print Name

FAX TO: School Nurse
508-655-2548

Please Complete Parental Consent →

(2)

WAYLAND PUBLIC SCHOOLS

PARENT/GUARDIAN PERMISSION ALLOWING THE ADMINISTRATION OF EPINEPHRINE (EPI-PEN) BY UNLICENSED SCHOOL PERSONNEL IN THE ABSENCE OF THE SCHOOL NURSE

Student's Name:_____ DOB:_____

Address:_____ Grade:_____

Parent/Guardian Name:_____

Home Phone:_____ Other Phone(s):_____ _____

If Parent/Guardian is unavailable in emergency, contact:

Name:_____

Phone(s):_____ _____

Relationship to student:_____

My son/daughter has the following allergy(s) which may require treatment with epinephrine (Epi-pen), according to my child's physician: _____

_____

****

CONSENT FOR TREATMENT

I give permission to allow the administration of epinephrine by auto-injection (Epi-pen) by the school nurse or, in the absence of the school nurse, by an unlicensed member of the school staff who has been trained and delegated by the school nurse to my son/daughter, in the event of an emergency. I also allow the school nurse to share with appropriate school personnel information relative to this medication administration plan.

_____ _____

Signature of Parent/Guardian Date