REQUEST FOR MEDICATION TO BE ADMINISTERED IN SCHOOL

TO BE COMPLETED BY FAMILY PHYSICIAN: Date_____

Name of child _____
Name of drug to be administered _____
Exact dosage of drug to be given _____
Time of administration in school _____
Duration of treatment _____

Signature of Physician _____
Address_____
Phone Number _____License Number _____

* * * * * * * * * *

TO BE COMPLETED BY PARENT: Date_____

I hereby request that the above medication be administered to my child by the school nurse at the designated hour prescribed by my physician, while

_____is attending school.
Name of student

In the absence of the school nurse, I give permission for the building principal to administer the medication as indicated.

Parent's Signature_____Date_____

* * * * * * * * * *

Please instruct your pharmacist to label the bottle of medication with your child's name and the name and dosage of the prescribed medication.

To be completed each school year in cases of extended use of the medication.

Marilyn Pensabene R.N.
School Nurse

OVER

Long Beach Catholic Regional School

735 West Broadway
Long Beach, New York 11561
Tel: (516) 432-8900 • Fax: (516) 432-3841

Place Child's Picture Here

Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

Asthma Action Plan: Yes ____ No ____

✥ STEP 1: TREATMENT ✥

Symptoms:

- ☐ *If a food allergen has been ingested, but no symptoms:*
- ☐ *Mouth* — *Itching, tingling, or swelling of lips, tongue, mouth*
- ☐ *Skin* — *Hives, itchy rash, swelling of the face or extremities*
- ☐ *Gut* — *Nausea, abdominal cramps, vomiting, diarrhea*
- ☐ *Throat†* — *Tightening of throat, hoarseness, hacking cough*
- ☐ *Lung†* — *Shortness of breath, repetitive coughing, wheezing*
- ☐ *Heart†* — *Thready pulse, low blood pressure, fainting, pale, blueness*
- ☐ *Other†* _____
- ☐ *If reaction is progressing (several of the above areas affected), give*

The severity of symptoms can quickly change. †Potentially life-threatening.

Give Checked Medication:**
***(To be determined by physician authorizing treatment)*

- ☐ Epinephrine ☐ Antihistamine
- ☐ Epinephrine ☐ Antihistamine
- ☐ Epinephrine ☐ Antihistamine
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- ☐ Epinephrine ☐ Antihistamine

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

✥ STEP 2: EMERGENCY CALLS ✥

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine *may be needed.*

2. Dr. _____ at _____

3. Emergency contacts:

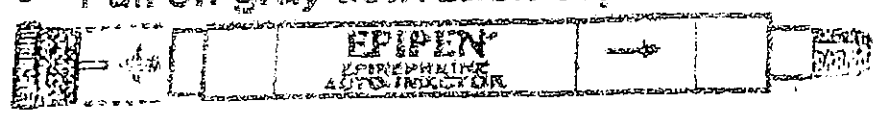
Name/Relationship	Phone Number(s)	
A _____	A _____	A _____
B _____	B _____	B _____
C _____	C	C

TRAINED STAFF MEMBERS

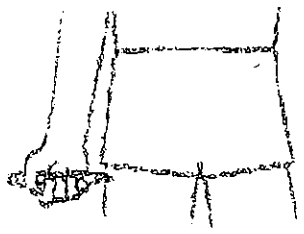
1. _____ Room _____
2. _____ Room _____
3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.

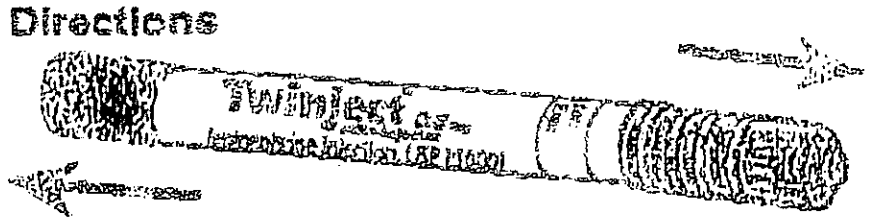


- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions



- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.

- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

"Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.

(To be completed by *Parent and Physician*)

LONG BEACH PUBLIC SCHOOLS
STUDENT ASTHMA ACTION PLAN

ID PHOTO

Name:_____ Grade:_____DOB:_____

Teacher:_____Room:_____

Parent/Guardian:_____Phone: (H)_____cell:_____

Address:_____Phone: (W)_____ pgr:_____

Parent/Guardian:_____Phone: (H)_____cell:_____

Address:_____Phone: (W)_____pgr:_____

Emergency Contact Persons:

Name:_____Relationship: _____ Phone:_____

Name:_____Relationship:_____Phone:_____

Physician Student Sees for Asthma:_____Phone:_____

Other Physician:_____Phone:_____

Does your child attend an afterschool program? _____YES _____NO If yes, what program_____

DAILY ASTHMA MANAGEMENT PLAN

- **Identify the things that start an asthma episode (Check each that applies to the student.)**

_____Exercise
_____Respiratory infections
_____Change in temperature
_____Animals
_____Food_____

_____Strong odors or fumes
_____Chalk dust
_____Carpets in the room
_____Pollens
_____Molds

Other_____
_____
_____

Comments_____

- **Peak Flow Monitoring**

  Personal Best Peak Flow number:_____

- **Daily Medications Home and School**

	Medicine	Amount	When to Use
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as_____

_____or has a peak flow reading of_____.

- During school hours, **contact the school nurse. If the school nurse is not available, the following steps should be taken during an asthma episode:**

A. Give **EMERGENCY ASTHMA MEDICATIONS** as listed below.

Medicine	Amount	When To Use
1. _____	_____	_____
2. _____	_____	_____
3._____	_____	_____
4._____	_____	_____

B. SEEK EMERGENCY MEDICAL CARE *AND* CONTACT THE PARENT/GUARDIAN IF THE STUDENT HAS *ANY* OF THE FOLLOWING:

- No improvement after initial treatment with medication.
- Hard time breathing with:
  - Chest and neck pulled in with breathing
  - Child is hunched over
  - Child is struggling to breathe
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are gray or blue

} ***IF THIS HAPPENS, GET EMERGENCY HELP NOW!***

COMMENTS / SPECIAL INSTRUCTIONS

_____

_____

FOR INHALED MEDICATIONS

_____ I have instructed_____in the proper way to use his/her medications. It is my professional opinion that_____should be allowed to carry and use that medication by him/herself.

_____It is my professional opinion that _____should not carry his/her inhaled medication by him/herself.

_____ _____

Physician signature Date

_____ _____

Parent signature Date