

WEST MILFORD TOWNSHIP PUBLIC SCHOOLS (WMTPS)

MEDICATION FORM FOR FOOD/INSECT ALLERGIC REACTION – 2 sided

This form must be completed by a PHYSICIAN/ADVANCED PRACTICE NURSE AND PARENT ANNUALLY for any student requiring Epinephrine while in school or at a school-sponsored event.

Student's Name: _____ DOB: _____ Grade: _____ School Year _____
 ALLERGY TO: _____ Weight _____
 Asthma Yes* () No () *Higher risk for severe reaction

Location of epinephrine (check all that apply): _____ with student _____ with nurse _____ other

SECTION 1 – SYMPTOMS:

		Give Checked Medication	
Systems:	If food allergen has been ingested or student stung by insect (if order is for insect sting allergy) but no symptoms:	() Epinephrine	() Antihistamine
Mouth	Itching, tingling or swelling of lips, tongue, mouth	() Epinephrine	() Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	() Epinephrine	() Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	() Epinephrine	() Antihistamine
Throat †	Itching and/or tightening of throat, hoarseness, hacking cough	() Epinephrine	() Antihistamine
Lung †	Shortness of breath, repetitive coughing, wheezing	() Epinephrine	() Antihistamine
Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	() Epinephrine	() Antihistamine
Other	Feeling something bad is about to happen, anxiety, confusion	() Epinephrine	() Antihistamine
	If reaction is progressing (several of the above areas affected)	() Epinephrine	() Antihistamine

† Potentially Life Threatening

Symptoms (The severity of symptoms can change quickly)

ACTION FOR A MINOR REACTION:

- If only symptoms are MINOR rash or MINOR skin itching, give **diphenhydramine** _____ mg liquid **OR** tablets. (_____ tsp. @ 12.5 mg per tsp. /diphenhydramine)
- Then call emergency contacts on file as provided by the parents/guardians and notify physician's office.

ACTION FOR A MAJOR REACTION:

- If symptoms progress, and/or person has cough, hoarseness of voice, tightness of throat, wheezing, and/or shortness of breath, **immediately** give:

_____ Epipen 0.3 mg	_____ Epipen Jr. 0.15 mg
_____ Auvi-Q 0.3 mg	_____ Auvi-Q 0.15 mg
_____ Adrenacllick 0.3mg	_____ Adrenacllick 0.15 mg

***** Epinephrine may be repeated in 5-7 minutes if symptoms do not improve*****

- Then call 911 and ask for advanced life support.** Call emergency contacts on file as provided by the parents/guardians and notify physician's office. Student must be transported to the nearest hospital.

TREATMENT BY A DELEGATE WHEN A NURSE IS NOT PRESENT (Please check one)

- ____ Delegate Order- In the absence of the school nurse, the order for antihistamine should be disregarded and Epinephrine may be administered by a trained delegate.
 ____ This student's order should not be delegated.

TREATMENT BY STUDENT (SELF-ADMINISTRATION) (Please check all that apply):

This student is both capable and responsible for self-administering this epinephrine. _____ yes _____ no

Physician Signature: _____ Date: _____ Physician Stamp: