Attachment I
Section A
Regulation 757-2

PRESCRIBED MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PHYSICIAN - *One form per medication

I certify that, in my opinion, it is medically necessary that the medication described below be administered to_____ during school hours and that this medication be administered by school personnel.

Student: _____ **DOB:** _____ **School**_____

Reason for medication: _____

Name of medication: _____

Dosage and time: _____

Symptoms for repeating medication: _____

Duration: _____

Date of prescription: _____

Date: _____ **Name of physician:** _____
(Print)

Signature of physician: _____

Note: Please return this form with medication or have your physician mail or fax it back to your child's school, Attention: School Nurse.

Attachment I
Section B
Regulation 757-2

PARENT/GUARIDAN REQUEST FOR ADMINISTRATION OF MEDICATION FOR ALLERGIC REACTIONS

Student:_____ DOB:_____ School:_____

I/We, _____, agree to furnish the above requested medication in the ORIGINAL sealed container with the label intact. I/We are aware that non-medical personnel may be administering medication to my child. I/We authorize the school nurse to communicate with the physician as allowed by HIPAA. **I/We hereby release the Prince William County School District and all of its employees of and from any and all liability in law for damages either we or our child may incur as a result of this request.**

_____ _____
Signature of Parent or Guardian Date

Attachment II
Regulation 757-2

PRINCE WILLIAM COUNTY PUBLIC SCHOOLS
MANASSAS, VIRGINIA 20108

PERMISSION FOR STUDENT TO SELF-CARRY EPIPEN

- ☐ I have instructed _____ on the signs and symptoms of his/her allergic reactions that would require reporting to school personnel.

- ☐ It is my professional opinion that _____ should carry his/her EpiPen with him/her at all times. (EpiPen shall be kept in school office otherwise.)

_____ _____
Physician/Nurse Practitioner Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal/Designee Signature Date

Food Allergy Action Plan

Place Child's Picture Here

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

ALLERGY TO:_____

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

◆ 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
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ Epinephrine ☐ Antihistamine
☐ 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. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

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*