

EMERGENCY HEALTH CARE PLAN
EPI-PEN® ADMINISTRATION

6/07

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 administer / self-administer and carry 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# _____

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: