NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

MEDICATION ORDER TO CARRY EPI PEN

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT TO CARRY PRESCRIBED EPI FOR SEVERE ALLERGIC REACTIONS

(Use medication Order to Carry Asthma Inhaler for asthma treatment. Medication Order to Carry for other medications.)

For online forms: *http:/sbo.nn.k12.va.us/healthservices/medications.html*

These requests are exceptions to School Board Policy JLCD and must be approved.

1. ***Parents will submit the following forms*** *(all forms must be in order and signed):*
   - ***a. Request for Approval for Students to Carry Prescribed Medication***
   - ***b. Part 1 front and back*** *(completed by parent)*
   - ***c. Part 2 and Part 3*** *(signed by the medical provider, parent and student)*
   - ***d. Responsibilities of Students and Parent Requesting Exception to Categories BSC and BESO in the Rights and Responsibilities Handbook (BSC: Behaviors that Present a Safety Concern and BESO: Behaviors that Endanger Self and Others)*** *(completed and signed by parent and student)*

2. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*

3. *The school nurse will complete an Emergency Care Health Plan. (see LAMP)*

4. *The Registered Nurse (School Nurse) will review the request and contact the prescribing physician if indicated.*

5. *The Health Services supervisor and the school medical advisor will be contacted if there are any questions about approval.*

6. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*

7. *The parents will sign a form assuming full responsibility and releasing the school of liability.*

8. *The school's registered nurse and principal will sign approving the request.*

9. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*

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REQUEST FOR APPROVAL FOR STUDENT TO CARRY PRESCRIBED MEDICATION

***This form is to be completed by the parent*. The medical provider must complete the appropriate medication order: (Please use the appropriate request: Asthma for inhalers, Epi pen for severe allergies or other medications)**
For online forms: *http:/sbo.nn.k12.va.us/healthservices/medications.html*

Name of Student: _____ Birth date: _____

Home Address: _____

Name of Parent(s): _____

Medication to be carried: _____

Reason student needs to carry: _____

_____

Additional information: _____

I request my son/daughter to carry the above-prescribed medication. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. ***I have attached a medical provider's order with the required information stating the student must carry.*** *I understand this request is for the current school year only.*

_____ _____
Parent's Signature *Date*

Attached and completed: (All must be reviewed by RN)
___ *Signed order from Medical Provider that student is trained and able to carry*
___ *Parent signature to request*
___ *Exception to Categories BSC and BESO (parent and student signed)*
___ *Medical Release of Liability*

Notes:_____
_____
_____

Approved for current school year:
_____*, RN* _____
School Nurse *Date*
_____ _____
Principal *Date*

R-12/21

Life-Threatening Allergy Management Plan (LAMP)

Student:	School:	Effective Date:
Date of Birth:	Grade:	Homeroom Teacher:

Dear Parent/Guardian: please provide the information requested below to help us care for your child at school.

Part 1- Medical history and contact information. To be completed by parent/guardian.
Part 2- Have your child's medical provider complete this section unless the medical provider's office prefers to use his/her own Life Threatening Allergy Management Plan which must include all components.

Please note: A medical provider's order must be submitted to the school nurse at the beginning of each school year and whenever modifications are made to this plan.

Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

PART 1—TO BE COMPLETED BY PARENT/GUARDIAN		
Contact Information:		
Parent/Guardian #1:		
Address:		
Telephone-Home:	Work:	Cell:
Parent/Guardian #2:		
Address:		
Telephone-Home:	Work:	Cell:
Other emergency contact:		
Address:	Relationship:	
Telephone-Home:	Work:	Cell:
Medical provider treating severe allergy:		Office #:
Please answer the following questions:		
1. What is your child allergic to?		
2. What age was your child when diagnosed?		
3. Has your child ever had a life-threatening reaction?	☐ Yes	☐ No
4. What is your child's typical allergic reaction?		
5. Does your child have asthma?	☐ Yes	☐ No
6. Does your child know what food/allergens to avoid?	☐ Yes	☐ No
7. Does your child recognize symptoms of his/her allergic reaction?	☐ Yes	☐ No
8. Will you be providing meals and snacks for your child at school?	☐ Yes	☐ No
9. Will your child always eat the school provided breakfast and/or lunch?	☐ Yes	☐ No
10. How does your child travel to school? ☐ Bus # _____ ☐ Car ☐ Walk		

Part 2: Life-Threatening Allergy Management Plan

To be completed by MD: Valid for Current School Year _____

Name: _____ DOB: _____Weight_____

Allergy to: _____

Asthma: □ Yes (high risk for severe reaction) □ No □ See Asthma Action Plan

Extremely Reactive to: _____

If known exposure, give epinephrine immediately and call 911.

Action for Mild Reaction:

Systems:	Symptoms:
Mouth:	itchy mouth
Skin:	minor itching "and/or" a few hives
Gut:	mild nausea/discomfort

Liquid

□ Diphenhydramine (12.5mg//5ml) p.o. (can be repeated q 4-6 hours)

□ Cetirizine (5mg/5ml) p.o. (do not repeat)

Dose: _____

Stay with student. Alert parent. If symptoms worsen then follow steps for major reaction.

Action for a Major Reaction: (two systems or single severe symptom)

Systems:	Symptoms:
MOUTH	swelling of the lips, tongue, or mouth
THROAT	tight throat, hoarseness, drooling, trouble swallowing
LUNG	shortness of breath, repetitive cough and/or wheezing
HEART	thready pulse, faint, confused, dizzy, pale, blue
SKIN	multiple hives, swelling about the face and neck
GUT	abdominal cramps, vomiting

1. Inject Epinephrine immediately intramuscularly

□ Epipen® □ Epipen® Jr □ Auvi-Q™ 0.30mg □ Auvi-Q™ 0.15mg □ _____

2. Call RESCUE SQUAD 911 ASK FOR ADVANCED LIFE SUPPORT

- **Students should not suddenly sit up, stand or be placed in the upright position. This increases risk for sudden death.**

3. Note time epinephrine was given and repeat dose after 5 minutes if no improvement or worsening symptoms.

- **Antihistamines and inhalers are not first line therapy in a severe reaction.**

4. Transport via EMS to the emergency department.

Emergency Contacts:

Parent/Guardian_____ Phone: _____

Other emergency contact_____Phone:_____

_____ _____ _____ _____

Parents Signature **DATE** **DOCTOR'S SIGNATURE** **DATE:**

_____ _____ **Print MD Name: _____**

Nurses Signature **DATE** **Contact number: _____**

Part 3: Life-Threatening Allergy Management Plan (LAMP)

Permission to Carry and/or Self-Administer Epinephrine (if appropriate)

Name: _____ DOB: _____

I, as the Healthcare Provider, certify that this child has a medical history of severe allergic reactions has been trained in the use of the prescribed medication(s) and is judged to be capable of carrying and self-administering this medication(s). The nurse or the appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

☐ Self-Carry

☐ Self-Administer

_____	_____	_____
Healthcare Provider Signature	Print Healthcare Provider name	Date

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In accordance with the Code of Virginia Section 22.1-274, I agree to the following:

I will not hold the school board or any of its employees liable for any negative outcome resulting from the self-administration of said emergency medication by the student.

I understand that the school, after consultation with the parent(s) may impose reasonable limitations or restrictions upon a student's possession and/or self-administration of said emergency medication relative to the age and maturity of the student or other relevant consideration.

I understand that the school may withdraw permission to possess and self-administer the said emergency medication at any point during the school year if it is determined the student has abused the privilege of possession and self-administration or that the student is not safely and effectively self-administering the medication.

_____	_____
Parent/Guardian Signature	Date
_____	_____
Student Signature	Date

Life-Threatening Allergy Management Plan (LAMP)

I give permission to the school nurse and designated school personnel, who have been trained and are under the supervision of the school nurse of _____ School, to perform and carry out the severe allergy tasks as outlined in _____ (Child's name) Life Threatening Allergy Management Plan (LAMP) as ordered by the physician. I understand that I am to provide all supplies necessary for the treatment of my child's severe allergy at school. I also consent to the release of information contained in the LAMP to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above named physician regarding my child's severe allergy.

Parent's Name	
Parent 's Signature	**Date**
School Nurse's Name	
School Nurse's Signature	**Date**

Every effort possible will be made to keep your child away from the stated allergen.

However, this does not guarantee that your child will never come into contact with the stated allergen in the school setting.

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RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO Category BSC (over the counter medications) AND Category BESO (prescription medications) (Request to Carry Prescribed Medication on One's Person)

I request my son/daughter _____carry the following prescribed medication: _____.

I have read Category BSC and Category BESO which state:

> ***Category BSC:*** *Drugs: Violating school board non-prescription medication policy and look-alike drug policy. Alcohol: Distributing alcohol to other students. Drugs: Possessing drug paraphernalia.*

Category BESO: *Drugs: Possessing controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Being under the influence of controlled substance, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Using controlled substances or using illegal drugs or synthetic hallucinogens or unauthorized prescription medications. Drugs: Distributing controlled substances or prescription medications or illegal drugs or synthetic hallucinogens or alcohol to other students.*

I understand that approval of this request does not release my son/daughter from penalty if he/she misuses this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will in student discipline equal to those violations of Levels 3-5, including short term removal from school to long-term suspension or expulsion.

I have read, reviewed and explained this information to my son/daughter. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Signed_____ (Parent) Date: _____

Signed_____ (Student) Date: _____

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MEDICATION RELEASE OF LIABILITY FORM

Student: _____ School: _____ Grade: _____

Address: _____

Parent/Guardian: _____ Phone: #_____
(Home)

_____ Phone #_____
(Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of_____

I hereby request and authorize you to assist and/or give

_____
(Dose and Medication)

to: _____, as prescribed by
(Student's Name)

_____. I release school personnel from liability
(Medical Provider's Name)

should reactions result from this medication, whether self-administered by my child or given by school personnel. If possible, I prefer follow-up care and transportation as follows:

_____

_____

_____ _____
Parent/Guardian Signature Date

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