

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 Epi Pen***
 - b. ***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)
 - c. ***Medication Release of Liability form***
 - d. ***LAMP Part 1 front and back*** *(completed by parent)*
 - e. ***LAMP Part 2 and Part 3*** *(signed by the medical provider, 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.*



Health Services

12465 Warwick Boulevard, Newport News, VA 23606-3041 ■ phone: 757-591-4646 ■ fax: 757-595-2017

REQUEST FOR APPROVAL FOR STUDENT TO CARRY EPI PEN

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



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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 result 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: _____

R-04/25



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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

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 physician complete this section unless the physician's office prefers to use his/her own Life Threatening Allergy Management Plan which must include all components.

Please note: A physician'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:
Physician 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?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. What is your child's typical allergic reaction?		
5. Does your child have asthma?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does your child know what food/allergens to avoid?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does your child recognize symptoms of his/her allergic reaction?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Will you be providing meals and snacks for your child at school?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Will your child always eat the school provided breakfast and/or lunch?		
		<input type="checkbox"/> Yes <input type="checkbox"/> No
10. How does your child travel to school?		
<input type="checkbox"/> Bus # _____ <input type="checkbox"/> Car <input type="checkbox"/> Walk		

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. If stock epinephrine is used for a student that has a known allergy and the parents/guardian has not provided the epi pen ordered by their medical provider, the parent/guardian will have to pay the restock price to NNPS. The student can be medically excluded until the parent/guardian provides the ordered epi pen and/or medical instructions. 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.

Whenever epinephrine is given at school, 911 is called and the student is transported to the hospital.

Life-Threatening Allergy Management Plan (LAMP)

To be completed by provider

Valid for School Year _____

Name: _____ DOB: _____ Weight: _____

Life Threatening Allergy to: _____

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

Systems:

MOUTH

THROAT

LUNG

HEART

SKIN

GUT

Symptoms:

swelling of the lips, tongue, or mouth

tight throat, hoarseness, drooling, trouble swallowing

shortness of breath, repetitive cough and/or wheezing

thready pulse, faint, confused, dizzy, pale, blue

multiple hives, swelling about the face and neck

abdominal cramps, vomiting

Administer Epinephrine immediately (Can repeat after 5 minutes if no improvement):

☐ Epinephrine 0.3 mg IM (≥ 25 kg) ☐ Epinephrine 0.15 mg IM ($12 < 25$ kg)

☐ Epinephrine 0.1 mg IM (<12 kg) ☐ Epinephrine ____mg INTRANASAL

If child at school or daycare

If home management is not approved

Call 911
and
transport
now

Action for Mild Reaction:

Systems:

MOUTH

SKIN

GUT

Symptoms:

itchy mouth

minor itching
"and/or" a few hives

mild nausea

Liquid medication:

☐ cetirizine (5mg/5ml) p.o

Dose: _____

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

Dose: _____

OR

Stay with child. Alert parents. If symptoms worsen, then follow steps for major reaction.

Emergency Contacts:

Parent/Guardian _____ Phone: _____

PARENT'S SIGNATURE

DATE

HEALTHCARE PROVIDER'S SIGNATURE

DATE

NURSE'S SIGNATURE

DATE

Print Healthcare Provider's Name: _____

Contact Number: _____

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

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