Chelmsford Public Schools

Allergy Medication Administration Plan and Consent

Student: _____Date of Birth_____ Weight:_____ Grade:_____ Homeroom: _____

Allergy to: _____

(Check one) ☐ SKIN tested positive to allergen

☐ BLOOD tested positive to allergen

☐ Not tested

Is student ASTHMATIC? ☐ Yes ☐ No

Diagnosis Oral allergy syndrome? ☐ Yes ☐ No

History of Eczema? ☐ Yes ☐ No

Has an EpiPen ever been administered? YES____ NO_____ Date EpiPen Last *Administered*: _____

Past Reaction Type (Rash vs. Vomit/ Breathing changes) _____

Are there situations where this child can consume or touch the allergen without symptom development? (i.e. wheat allergy, but may touch play dough, egg allergy but eats eggs cooked in baked goods)_____(if so ensure your MD comments.*

*If more than one allergy, please explain the different reactions:*_____

**** MD to complete****

The **Health Care Provider** must write orders.

Please Note: *Due to State Laws, the nurse can not delegate assessment skills and/ or the administration of "as needed" medications such as Benadryl. If there is a question whether a child, who has been prescribed an EpiPen is having an allergic reaction, the EpiPen will be administered. It is the policy of Chelmsford Public Schools not to use Twin-Jet Epinephrine Systems as a method of treatment.*

1. Give Medication(s)

	Dose	Route	Frequency	When to Use	Side Effects

- It is my professional opinion that this child should be provided with a table section where efforts are made to exclude the listed allergen _____ Yes_____ No_____
- Additional school environment measures needed or exceptions:_____

Prescriber's Name (Print) _____ Phone # _____

Prescriber's Signature _____ **Date** _____

Must be manual, may not be rubber-stamped, according to the Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices & Policy Guidelines adopted Aug. 1, 1989 and amended Dec. 12,2001.

2. After epinephrine given, call 911

3. Contact Parents/Guardians

Parent/ Guardian _____/_____/_____/_____
(Print Name) (Home #) (Cell #) (Work #)

Parent/ Guardian _____/_____/_____/_____
(Print Name) (Home #) (Cell #) (Work #)

Emergency Contact_____/_____/_____/_____
(Relationship to child) (Home #) (Cell #) (Work #)

4. Call Physician (print name)_____ Phone # _____

Complete guardian consents on the back of this form

Allergy Medication Administration Plan and Consent …continued

Student:_____ Date of Birth_____ Weight_____ Grade_____ Homeroom _____

Field Trip In event of field trip and/or **Extended Day Programs**: (Please initial all that apply)

____ * My child may self-administer if my child can demonstrate competency. **(* Nurse to assess and evaluate "Yes" below**).

____ I or my designee will attend my child's field trips and assume responsibility for my child's medical & medication needs.

____ I give permission for a responsible adult, trained by the school nurse, to give my child this medication. **Please Note:** *Due to State Laws, the nurse cannot delegate assessment skills and/ or the administration of "as needed" medications such as, but not limited to, Benadryl or Albuterol. However, due to a State Waiver, the nurse is permitted to train staff in the administration of an EpiPen to children who have them prescribed. If there is a question that a child, who has been prescribed an EpiPen, is having an allergic reaction, the EpiPen will be administered, and the emergency services will be summoned.*

For my child's safety, I give the school nurse permission to:

Yes _____ No _____ Share information relative to my child's allergy with appropriate personnel as necessary for my child's safety and health.

Yes _____ No _____ **(*Elementary)** Have my child sit at a section of the lunch table where efforts are made to avoid their allergen.

Yes _____ No _____ (***Elementary)** Send home a general letter to the parents of the other children in my child's classroom notifying them of the fact there is a child in the classroom (your child's name will not be mentioned in the letter) with an allergy. *However, please note that schools cannot ensure that foods brought by classmates for their own consumption are free of trace allergens or been affected by cross-contamination. If desired, you may supply "safe treats" for your child in the event of special classroom celebrations at which food is served.*

Yes _____ No _____ Photograph and display my child's picture to the appropriate staff, so they are able to recognize my child has an EpiPen prescribed for an allergic condition.

Yes_____ No _____ The school nurse may speak to the listed Health Care Provider for clarification for allergy concerns.

Parent/Guardian's Signature _____ Date_____

Please list all the medications the child currently takes *(if this changes at any time during the school year, please contact the school nurse):* _____

Please note: *All medications must be in their original and/or pharmacy- labeled containers and delivered to the nurse by a responsible adult and may be retrieved by the parent/guardian at any time. Medications will be disposed of if they are not picked up within one week following the order's termination or at the completion of the last day of school.*

For Health Office Use Only

Student has demonstrated competency in medication self administration:

____Yes ____No _____Date Nurse's name printed: _____ Nurse's signature: _____
____Yes ____No _____Date Nurse's name printed: _____ Nurse's signature: _____
____Yes ____No _____Date Nurse's name printed: _____ Nurse's signature: _____

Medication storage location: _____ Date Medication EXPIRES: _____