Med.RX-2

FOR SCHOOL USE:
Date Received: _____
By: _______________

BRUNSWICK CITY SCHOOLS

PRESCRIBER AUTHORIZATION FOR THE USE OF EPINEPHRINE AUTOINJECTOR

All of the following information must be completed. If the response is "none" or "not applicable" it must indicated

Name of Student: ____ School: ___________________ Grade: ______

Address: ____ Birthdate: _______________

Known Allergies: ____

Dosage: ☐ Epinephrine 0.3 mg ☐ Epinephrine 0.15 mg or ☐ ____________ Call 911 if given

Date administration is to begin: ☐ Upon receipt or ☐ ____________
Date administration is to cease: ☐ End of school year or ☐ ____________

- The student is capable of possessing and using the auto injector appropriately Yes ☐ No ☐
- The student has been trained on the proper use of the auto injector Yes ☐ No ☐
- If either of the above are marked "No" student may not carry auto injector. **One epinephrine auto-injector is REQUIRED to be stored in the school clinic.**

The Epinephrine auto injector should be used for the following symptoms (check all that apply):

☐ If ingested or exposed to allergen but has no symptoms

☐ Mouth – Itching, tingling

☐ Mouth – Swelling of lips, tongue, mouth

☐ Skin – Hives, itchy rash, swelling of the face or extremities

☐ Stomach – Nausea, abdominal cramps, vomiting, diarrhea

☐ Throat – Tightening of throat, hoarseness, hacking cough

☐ Lungs – Shortness of breath, repetitive coughing, wheezing

☐ Heart – Thready pulse, low blood pressure, fainting, pale, blueness

☐ Other – If reaction involves more than one of the above symptoms

☐ Other – ____

Procedure to follow if student is unable to administer the anaphylaxis medication:

☐ Trained staff to assist and call 911; or ____

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis:

____

Adverse reactions to be reported to prescriber: ____

Any severe adverse reactions that may occur to another child, for whom the auto injector is not prescribed, should such a child receive a dose of the medication: ____

Other special instructions: ____

Prescriber's Signature: ____ Date: ___________________

Prescriber's Printed Name: ____ Emergency Phone: ________________

FOR SCHOOL USE:
Date Received: ____
By: ______________

BRUNSWICK CITY SCHOOLS

PARENT/GUARDIAN Authorization for Epinephrine to be Taken During School Hours

Before any medication/treatment can be given the following must be completed and received by the school office:

- Licensed prescriber form completed in full
- Parent/Guardian portion completed in full
- Medication received in the original pharmacy labeled container
- **One epinephrine auto-injector is REQUIRED to be stored in the school clinic.**
- New forms must be completed every school year

School: ___________________________________ Grade: ______ School year: _____________

Student's Name: Last: _____________________________ First: ___________________ Date of Birth: ________

Address: Street: _________________________________ City: ____________________ Zip: ___________

☐ Yes ☐ No Child carries own epinephrine auto-injector
If yes, it will be kept in ☐ bookbag ☐ purse ☐ pocket ☐ other __________________

Description of past allergic reaction: ____

____

Bus: If student carries an epinephrine auto-injector, the bus driver will assist/administer the medication and summon 911 as per policy. If medication is unavailable, 911 will be called.

I have read and understand the Brunswick City Schools guidelines for medication. I understand that the Brunswick City School District and any of its personnel are absolved from any responsibility or liability, which might be associated with the administration of such medication. I agree to notify the school if there is a change in licensed prescriber; to notify the school if the medication, dosage or procedure is changed or discontinued. I agree to submit a revised statement signed by the licensed prescriber to the person designated to administer the medication, if any of the information provided by the licensed prescriber of the medication changes. Parent/Guardian is responsible for safe delivery of the medication to the school clinic. I give consent to the school health staff to have reciprocal communication with the licensed prescriber regarding this order. Parent/Guardian is responsible to pick up any unused medication when the medication is discontinued or at the end of the school year. Medication will be destroyed 5 days after the end of the school year. It is parent/guardian responsibility to inform supervisors of before and after school activities (i.e. sports teams, book clubs etc.) of child's medical concerns, possible need for medication, treatment and of written plans.

Check all that apply (if not checked, it is a no answer)
☐ Yes ☐ No My child must sit at a table designated "Peanut/Nut free" during lunch.
☐ Yes ☐ No I give permission for school to post health information and picture of my child to assist in identification during an emergency situation.
☐ Yes ☐ No My child may make food choices independently.
☐ Yes ☐ No My child may eat food brought in for birthdays, celebrations etc.
☐ Yes ☐ No I will supply safe snacks for my child to eat in place of birthday or celebration treats.

Parent/Guardian Signature: ____ Date: ______________

Home Phone: _________________________________ Emergency Phone: _________________________________