



**Dear Healthcare Provider:** Your patient’s legal guardian has requested that a PRESCRIBED MEDICATION or an OVER THE COUNTER(OTC) MEDICATION be given to their child at school. Most medications should be taken at home unless there is a specific lunchtime dose, or the prescribed medication is needed in the event of an emergency or prescribed PRN medication like epi-pen, inhaler, migraine medication, etc.

**All medications taken at school must have parental consent for administration, a medical order and be in the original pharmacy labeled containers. These medications will be stored in the nurse’s office.**

### TO BE COMPLETED BY PARENT:

<i>Scholar Name</i>	<i>Date of Birth</i>	<i>Grade</i>

I understand fully the directions that have been given to the school nurse or other licensed school health staff by my child’s physician. I agree to permit the school nurse or other licensed health care staff to administer the medication as directed.

I hereby authorize the Catalyst Academy Health Staff to contact the medical provider (named below) regarding this medication and to release information regarding my child (named above) to said provider. I hereby authorize the medical provider to release information about my child and this medication to the Catalyst Academy Health Staff regarding any medical concerns about this medication order.

I understand that to protect the limited confidentiality of medical information, my agreement to release information is necessary and that this permission is limited for the purpose and to the person or entity mentioned above and will be in effect for the current school year. I understand that the disclosed information will be kept confidential and the releasing facility will not be responsible for re-disclosure of the information. I also understand that this consent is revocable with written, or if necessary, verbal notice, except to the extent that action has been taken in reliance thereon.

<i>Signature of Parent/Guardian/Legal Rep.</i>	<i>Printed, parent/guardian/legal rep.</i>	<i>Date</i>
<i>Daytime phone number</i>		

### TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT CLEARLY)

<b>Diagnosis:</b>
<b>Medication:</b>
<b>Dose/route/schedule:</b>
<b>PRN (indication and timing)</b>
<b>List serious reactions to the medications:</b>  <b>List appropriate responses:</b>

**Physician Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**Address and Zip:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  **Yes (higher risk for a severe reaction)**  **No**

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_








**THEREFORE:**

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:





## SEVERE SYMPTOMS

 <b>LUNG</b> Shortness of breath, wheezing, repetitive cough	 <b>HEART</b> Pale or bluish skin, faintness, weak pulse, dizziness	 <b>THROAT</b> Tight or hoarse throat, trouble breathing or swallowing	 <b>MOUTH</b> Significant swelling of the tongue or lips
 <b>SKIN</b> Many hives over body, widespread redness	 <b>GUT</b> Repetitive vomiting, severe diarrhea	 <b>OTHER</b> Feeling something bad is about to happen, anxiety, confusion	<b>OR A COMBINATION</b> of symptoms from different body areas.

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1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS

 <b>NOSE</b> Itchy or runny nose, sneezing	 <b>MOUTH</b> Itchy mouth	 <b>SKIN</b> A few hives, mild itch	 <b>GUT</b> Mild nausea or discomfort
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**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

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**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.1 mg IM  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

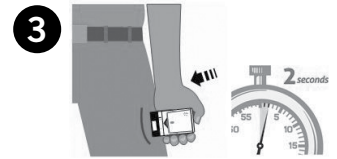
Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

\_\_\_\_\_

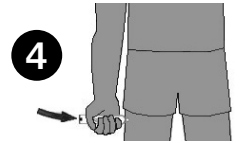
## HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



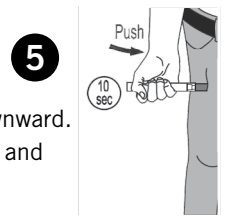
## HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



## HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



## ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

## OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

### EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: \_\_\_\_\_

DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

### OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME/RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

# Asthma Action Plan

(To be completed by Doctor/Nurse)

**Return Color Copy To The School Nurse**

Name \_\_\_\_\_

School \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Parent's Phone \_\_\_\_\_

Doctor/Nurse's Name \_\_\_\_\_

Doctor/Nurse's Office Phone \_\_\_\_\_

Emergency Contact After Parent \_\_\_\_\_

Contact Phone \_\_\_\_\_

**Asthma Severity:**  Mild Intermittent     Mild Persistent     Moderate Persistent     Severe Persistent

**Asthma Triggers:**  Colds     Exercise     Animals     Dust     Smoke     Food     Weather     Other: \_\_\_\_\_

## TAKE THESE MEDICINES EVERYDAY

### Child feels good:

- Breathing is good
- No cough or wheeze
- Can work/play
- Sleeps all night



MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Green

**Peak flow in this area:**

\_\_\_\_\_ to \_\_\_\_\_

**20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:**

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## IF NOT FEELING WELL

## TAKE EVERYDAY MEDICINES AND **ADD** THESE RESCUE MEDICINES

### Child has any of these:

- Cough
- Wheeze
- Tight Chest



MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Yellow

**Peak flow in this area:**

\_\_\_\_\_ to \_\_\_\_\_

*Call your doctor/nurse's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than \_\_\_ days. After \_\_\_\_\_ days go back to GREEN ZONE and take everyday medications as instructed.*

## IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW!

## TAKE THESE MEDICINES

### Child has any of these:

- Medicine not helping
- Breathing is hard and fast
- Lips and fingernails are blue
- Can't walk or talk well



MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Red

**Peak flow below:**

\_\_\_\_\_

**IF UNABLE TO CONTACT YOUR DOCTOR OR NURSE:**  
Call 911 or go to the nearest emergency room and bring this form with you!

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_

**It is my professional opinion this child should carry his/her inhaled medication by him/herself.**

Adapted from the  
NYC Childhood  
Asthma Initiative

Adapted forms  
the NHLBI

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