Clinic Use LOCATION OF EMERGENCY MEDICATION(S) AT SCHOOL: _____Self-Carry ☐ Location: _____

ALLERGY EMERGENCY
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

Parent/Guardian:	**Parent/Guardian:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

Allergic to: _____
Symptoms: _____

MILD/MINOR SYMPTOMS


Itchy, runny nose, sneezing

OR


Itchy Mouth

OR


Localized rash, a few hives

OR


Nausea, vomits 1 time

Give Antihistamine: _____Dose: _____ (by mouth)
Stay with student and observe for worsening symptoms **(if more than 1 symptom go to SEVERE)**
Notify Parent.

SEVERE SYMPTOMS


Shortness of breath, coughing, wheezing


Pale, bluish, faint, weak pulse, dizzy


Hoarseness, tight throat, difficulty swallowing


Swelling of tongue &/or lips


Several hives &/or redness all over


Vomiting more than once


Impending doom, anxiety

Give epinephrine injection: (circle) *EpiPen Auvi-Q Generic* **Dose:** _____(inject in the upper, outer thigh)
CALL 911 and notify parent****
OTHER (check if applicable): ☐ Give antihistamine _____ Dose _____
☐ Give inhaler _____ Dose _____

OPTION 1 OR 2 NEEDS TO BE COMPLETED AND SIGNED BY A PHYSICIAN IF STUDENT IS TO CARRY AND/OR SELF-ADMINISTER EPINEPHRINE:

☐ **1.** I have instructed student in the proper use and dosage of his/her epinephrine auto-injector. It is my professional opinion that this student should be allowed to carry and self-administer_____(medication name and dose).

☐ **2.** This student should be allowed to carry this epinephrine auto-injector while at school and on school bus. Student is not capable of administration of this medication_____ (medication name and dose).

Physician's Signature_____ Date:_____

School Clinic: Copy of plan to be provided to Transportation Supervisor

_____ _____
PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE / DATE

Information about students and family is strictly confidential.

Rev. 3/2023

Parent's Request and Authorization for Auto-Injectable Epinephrine

School Year: _____

STUDENT NAME: _____ DOB: _____

SCHOOL: _____ STUDENT ID: _____

Please check one of the following:

☐ **For students who will carry and self-administer auto-injectable epinephrine:**

I, the undersigned, parent or guardian of the above student consent to the above student carrying and self-administering auto-injectable epinephrine for the treatment of anaphylaxis at school, school sponsored activities, while under the supervision of school personnel and while in before-school or after-school care on school operated property.

☐ **For students who will not self-administer (will self-carry or keep auto-injectable epinephrine in the clinic):**

I, the undersigned, parent or guardian of the above-named student, do not believe that the student is able to self-administer auto-injectable epinephrine due to age and/or the following reasons _____. I hereby request that the above-named school receive, store, and administer the student's auto-injectable epinephrine or allow the student to self-carry and grant permission to school personnel to administer auto-injectable epinephrine for the treatment of anaphylaxis at school, school sponsored activities, while under the supervision of school personnel, and while in before-school or after-school care on school operated property.

Pursuant to Georgia Law (O.C.G.A. 20-2-776), I understand and agree to the following:

(1) I must provide a written statement from a physician licensed under Georgia law (O.C.G.A. § 43-34-20 through O.C.G.A. 43-34-46). The written statement must include the name of the medication, method, amount, and time schedules by which the medication is to be taken, and, if applicable, confirm that the student is able to self-administer auto-injectable epinephrine. The written statement must be provided annually and whenever there is a change in the medication, dosage, frequency of administration, or reason for administration as per Georgia law O.C.G.A. § 20-2-776 (b)(1) & O.C.G.A. § 20-2-776(g)(1.). The written statement should also indicate if the student should self-carry but is not able to self- administer.

(2) I give permission for _____(name of prescribing physician)to consult with the administrators, school nurses, or clinic workers of the above designated school at the request of the school personnel regarding any questions that may arise with regard to the auto-injectable epinephrine medication prescribed to the student. The aforementioned physician is authorized to disclose all protected health information of the student relating to any questions that may arise with regard to the auto-injectable epinephrine medication that the student is prescribed. This authorization shall expire one year after the date it is signed. This authorization may be revoked in writing at any time by submitting written revocation to: _____. The information disclosed to the District may be shared with other school officials consistent with FERPA; however, HIPAA does not apply to the District.

(3) The Gwinnett County Board of Education, the Gwinnett County School District and their employees and agents are released from civil liability for any adverse reaction that may occur as a result of the administration or self-administration of auto-injectable epinephrine per Georgia Law O.C.G.A. § 20-2-776(b)(2) & O.C.G.A. § 20-2-776(g)(2.)

For students who carry and self-administer:

(4) My student may be subject to disciplinary action if he or she uses auto-injectable epinephrine in a manner other than as prescribed.

_____ _____

Signature of Parent or Guardian Date

ADMINISTRATION OF MEDICATION REQUEST
(1 form per medication per student)

STUDENT NAME: _____ Date of Birth: _____
STUDENT NUMBER: _____ TEACHER: _____
SCHOOL: _____

For the safety of all students at our school, these guidelines should be followed:

1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over-the-counter, must be accompanied by **this form and brought to the school clinic by an adult.**
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. It is the responsibility of the parent/guardian to inform school of any changes and update medication forms. **Medications stored in envelopes, baggies, etc., will not be administered.**
   ALL MEDICATIONS NEED TO BE ADMINISTERED ACCORDING TO DIRECTIONS ON LABEL.
4. **Medications must be picked up at the end of the year, or the school will dispose of them.**

Name of Medication: Benadryl **Expiration Date:** _____

Reason Medication Given: Allergic Reaction

Amount to be Given: _____

Time(s) to be Given: _____

Possible Side Effects: _____

Special Instructions: _____

I, _____, grant permission for the principal or designee to assist in administration of medication listed above for my child, _____, while at school, or when on field trips.

I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Home: _____ Work: _____ Cell: _____

_____ _____
Signature of Parent Date

FOR CLINIC USE: ☐ Medication disposed of By _____ Date _____
☐ Medication picked up By _____ Date _____
(parent signature)

Rev. 5/2022

ADMINISTRATION OF MEDICATION REQUEST
(1 form per medication per student)

STUDENT NAME: _____ Date of Birth: _____
STUDENT NUMBER: _____ TEACHER: _____
SCHOOL: _____

For the safety of all students at our school, these guidelines should be followed:

1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over-the-counter, must be accompanied by **this form and brought to the school clinic by an adult.**
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. It is the responsibility of the parent/guardian to inform school of any changes and update medication forms. **Medications stored in envelopes, baggies, etc., will not be administered.**
   ALL MEDICATIONS NEED TO BE ADMINISTERED ACCORDING TO DIRECTIONS ON LABEL.
4. **Medications must be picked up at the end of the year, or the school will dispose of them.**

Name of Medication: Epinepherine Pen **Expiration Date:** _____

Reason Medication Given: Allergic Reaction

Amount to be Given: _____

Time(s) to be Given: _____

Possible Side Effects: _____

Special Instructions: _____

I, _____, grant permission for the principal or designee to assist in administration of medication listed above for my child, _____, while at school, or when on field trips.

I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Home: _____ Work: _____ Cell: _____

_____ _____
Signature of Parent Date

FOR CLINIC USE: ☐ Medication disposed of By _____ Date _____
☐ Medication picked up By _____ Date _____
(parent signature)

Rev. 5/2022