Delaware Military Academy

2019 National Blue Ribbon School
20 years STRONG in developing Citizens and Scholars to lead our Nation through the 21st century!

Self-Administration of Emergency Medication: Auto injectable Epinephrine Autoinjector Student Agreement

Name: _____ Grade: _____
Medication: Epinephrine Autoinjector Date: _____

I agree to:

- Follow my prescribing health professional's medication order.
- Use correct medication administration technique.
- Not allow anyone else to use my medication under any circumstances.
- Keep the medication with me at all times.
- Let someone know, if possible, when I need to take the epinephrine or immediately after taking it.
  - Someone needs to call 911 right away.
  - An adult needs to be informed of what is happening and the school nurse needs to be contacted if during the school day.
- The school nurse will:
  - Call 911 and arrange transportation to Emergency room. (Injected epinephrine only lasts 20-30 minutes.)
  - Contact Parent/Guardian/Relative Caregiver.
  - Stay with student. Keep student quiet, monitor symptoms, until paramedics arrive.
  - Observe for severe allergic reaction, hives, wheezing, difficulty breathing, swelling (face, neck), tingling/swelling of tongue, vomiting, signs of shock, loss of consciousness.
  - Other _____
- I understand that permission for self-administration of medication may be discontinued if am unable to follow the safeguards established above.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian/Relative Caregiver Date

☐ Student verbalizes Dose _____
☐ Student Demonstrates proper Technique
☐ Student verbalizes symptoms/signs of when medication is needed & when to notify school nurse
☐ Student verbalizes Safe Use
☐ Parent and licensed healthcare provider permission to self-administer

The student has demonstrated knowledge about the proper use of his/her medication.

_____ _____
Signature of School Nurse Date

112 Middleboro Road • Wilmington, DE 19804 • 302-998-0745 • 302-998-3521 Fax • www.demilacad.org

Your child's health record indicates s/he has severe allergies. Please have your healthcare provider, who is licensed to prescribe medication, complete this form or provide a written emergency plan with instructions for the school nurse and school nutrition supervisor.

STUDENT NAME:	**DATE OF BIRTH:**
SCHOOL:	**GRADE:**

PREVENTION & EMERGENCY RESPONSE PLAN FOR STUDENTS WITH ALLERGIES

The following sections must be completed by a MD, DO, APN, or PA, licensed to prescribe medications, with directives for care in the school setting.

Student has a life-threatening or severe allergy to:

	INGESTION	INHALATION	INJECTION (STING/BITE)	SKIN CONTACT
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

ACTION PLAN for life-threatening or severe allergic reaction:

Provide STAT treatment if the following symptoms occur after exposure to the life-threatening allergy (check below):

- ☐ Abdomen: nausea, stomach ache/cramping, vomiting, diarrhea
- ☐ General: panic, sudden fatigue, chills, fear of impending doom
- ☐ Mouth: itching, tingling, or swelling of the lips, tongue, or mouth
- ☐ Respiratory: shortness of breath, repetitive coughing, wheezing
- ☐ Skin: hives, itchy rash, swelling about face or extremities
- ☐ Throat: feeling tightness in the throat, hoarseness, hacking cough
- ☐ Other: _____

Treatment:

1. Administer epinephrine (dosage/route/interval) _____
2. Call 911
3. Continue with monitoring by the nurse until EMS arrives
4. Other: _____

Student may carry & self-administer epinephrine
□ YES □ NO

Prevention for exposure to known severe or life-threatening food allergies:

USDA regulation 7 CFR Part 15B requires substitution or modification in school meals for children with diagnosed severe or life-threatening food allergies.

Foods to omit:	**Substitutions:**	**Foods to omit:**	**Substitutions:**
☐ Eggs		☐ Milk	
☐ Whole	_____	☐ Milk	_____
☐ Ingredient in Recipe	_____	☐ Cheese	_____
☐ Other	_____	☐ Whey	_____
☐ Wheat	_____	☐ Ingredient in Recipe	_____
☐ Gluten	_____	☐ Other	_____
☐ Trace Amount	_____	☐ Nuts	_____
☐ Ingredient in Recipe	_____	☐ Tree Nut	_____
☐ Soy	_____	☐ Peanut	_____
☐ Soy Lecithin	_____	☐ Other	_____
☐ Oil	_____	☐ Fish	_____
☐ Isolated Soy Protein	_____	☐ Shellfish	_____
☐ Ingredient in Recipe	_____	☐ Other Not Included on List	_____
☐ Other	_____		

Non-severe and non-life threatening food allergies or intolerances should be listed below with appropriate substitutions.

The school food service will determine if reasonable accommodations can be made on a case by case basis.

Other Allergies: (circle) YES NO Indicate Allergies: _____

Asthma: (circle) YES NO _____

Response for reaction to all other allergens: *Give prompt treatment if the student has any of the following symptoms:*

_____

_____

Treatment:

1. Administer: _____
2. Contact: _____
3. Other: _____

Healthcare Provider Name (printed): _____ MD DO AP PA Date: _____

Healthcare Provider Name (signature): _____ Phone: _____

I give permission to the school nurse to administer this plan. I will supply medication in an original container and notify the school nurse of any changes. I understand that relevant school personnel will be notified of my child's allergies and that I will need to work with the school nutrition supervisor regarding any food allergies.

Parent Signature: _____ **Date:** _____ **Phone #:** _____