

GROTON-DUNSTABLE REGIONAL SCHOOL DISTRICT
ANAPHYLAXIS TREATMENT PLAN AND PHYSICIAN'S ORDER FORM

Student Name: _____	DOB: _____
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SECTION 1 - STUDENT ALLERGY HISTORY

1. Has this student had an anaphylactic reaction? No Yes, please state when and identify the offending agent:

2. Has this student ever been allergy tested? No Yes, date tested: _____
3. What is this student allergic to?

<input type="checkbox"/> Dairy	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Soy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eggs	<input type="checkbox"/> Sesame	<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Fin Fish	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Sting - Has venom testing been done? <input type="checkbox"/> Yes <input type="checkbox"/> No Has student been desensitized to the venom? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Has an EpiPen/EpiPen Jr been prescribed for this student? Yes No
5. Has the student and family been educated about the avoidance of the offending agent? Yes No
6. Has the student and family been educated in the indications for EpiPen/EpiPen Jr administration, checking outdated medicine, and storing the EpiPen/EpiPen Jr? Yes No
7. Does student have a medical alert bracelet? Yes No
8. In your opinion, is this student able to safely self-administer the EpiPen/EpiPen Jr? Yes No
9. Does the student have asthma? Yes No

SECTION 2 - GROTON-DUNSTABLE SCHOOL DISTRICT EPIPEN PROTOCOL

The Groton-Dunstable Regional School District has adopted the following protocol for the use of the EpiPen/Epipen Jr. This protocol will be followed for all students who have been identified by their physician as having an allergy with the potential for an anaphylactic reaction and for whom an EpiPen/EpiPen Jr has been prescribed:

1. A student who has been previously identified by his or her physician as having an allergy with the potential for an anaphylactic reaction, and who manifest signs of anaphylaxis, will be treated with EpiPen/EpiPen Jr. Administration is IM into anterolateral thigh.
2. Student dose (check one):

<input type="checkbox"/> EpiPen Jr 0.15mg
<input type="checkbox"/> EpiPen 0.30 mg
3. 911 will be called and the student will be transported to the nearest emergency department.
4. A second dose of EpiPen/EpiPen Jr may be given, if available, if EMS has not arrived and symptoms of anaphylaxis have not abated after 15 minutes.
5. Do you agree with the above treatment plan? Yes No
6. If you answered "no" to #5, please make modifications to this protocol regarding the indications and mode of treatment. Please specify medication(s) ordered, the order of administration, and the disposition of the patient. Please use back of page if necessary.

Date: _____	Prescriber's Signature: _____
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Printed Name: _____	Phone: _____
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The epinephrine administration plan for the Groton-Dunstable Regional School District is in conformity with Massachusetts Law: Section 1.105:210.100. We do our best to minimize student exposure to the common allergens. Our personnel are trained to administer Epinephrine in conformity with the recommendations of the Mass. DPH guidelines. The GDRSD Anaphylaxis Protocols have been developed in accordance with current recommendations and guidelines published by the AAAAI, AAP and the AA

I have read, understood and I am in agreement with the physician order for the treatment plan for anaphylaxis.

Date: _____	Parent Signature: _____
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GROTON-DUNSTABLE REGIONAL SCHOOL DISTRICT
 PARENTAL CONSENT FOR THE ADMINISTRATION OF EPINEPHRINE IN SCHOOL

SECTION 1 - STUDENT INFORMATION

Student Name: _____		DOB: _____	
Building: _____		Grade: _____	
Building: _____		Bus #: _____	
1. What is your child allergic to?	<input type="checkbox"/> Dairy	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Soy
	<input type="checkbox"/> Eggs	<input type="checkbox"/> Sesame	<input type="checkbox"/> Sting
	<input type="checkbox"/> Fin Fish	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Tree Nuts
2. Has your child ever been allergy tested? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date tested: _____			
3. Does your child have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION 2 – PARENTAL CONSENT

1. I give permission to the school nurse and the school doctor to discuss treatment of the aforementioned student with the student’s physician: <input type="checkbox"/> Yes <input type="checkbox"/> No List doctor’s name: _____	
2. I give permission to the school nurse or her designee to administer EpiPen/EpiPen Jr to the aforementioned student. I understand that it will be injected into the muscle of his/her leg or arm: <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has your child been trained to self-administer EpiPen/EpiPen Jr? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often do you review self-administration? _____	
4. I give permission for the aforementioned student to carry his/her EpiPen/EpiPen Jr: <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. How many EpiPen/EpiPen Jr will you provide to the school? _____	
6. Where will the EpiPen/EpiPen Jr be kept? _____	
7. What is the expiration date of the EpiPen/EpiPen Jr.? _____	
<i>In order to ensure that your child will receive this life preserving medicine promptly when indicated, we are obligated to inform appropriate school personnel. Your signature below gives us permission to do so.</i>	
Date: _____	Parent/guardian Signature: _____
Printed Name: _____ Relationship: _____	
Tel: (H): _____ (W): _____ (C): _____	
Please return this form to: Phyllis Lang, RN @ Florence Roche School, PO Box 738, Groton, MA 01450 Fax: 978-448-3988 Phone: 978-448-6665	