EPI-PEN MEDICATION FORM

Name..... **DOB**..... **Teacher**.....

ALLERGY TO---------- **Asthmatic __ Yes __ No (check one)**

STEP 1 - TREATMENT

SYMTPOM	Give Epinephrine	Give Antihistamine
If a food allergen has been ingested but no symptoms:		
• Mouth: Itching, tingling or swelling of lips, tongue, mouth		
• **Skin:** Hives, itchy rash, swelling of face or extremities		
• Gut: Nausea, abdominal cramps, vomiting, diarrhea		
• Throat: tightening of throat, hoarseness, hacking cough		
• Lung: Shortness of breath, repetitive coughing, wheezing		
• Heart: Weak or thready pulse, low blood pressure, fainting, pale, blueness		
• Other		
• If reaction is progressing (several of the above) give:		

Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen Epipen, Jr Twinject 0.3 mg Twinject 0.15mg

Antihistamine Administer _____
(medication/dose/route

PERMISSION TO SELF ADMINISTER

This student is both capable and responsible for self-administering this medication:

_____No _____Yes - Supervised _____ Yes - Unsupervised

STEP 2 - EMERGENCY CALLS

1. Call 911- State that an allergic reaction has been treated and additional epinephrine may be needed
2. **Parent** _____ __ **Phone#** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
3. **Parent** _____ __ **Phone#** _____

Emergency Contacts: Name & Relationship

_____ **Phone#**_____ __

_____ **Phone#**_____

DOCTOR'S SIGNATURE _____ Date _____

(Required)

PARENT/GUARDIAN SIGNATURE_____ Date _____

THOMAS JEFFERSON MIDDLE SCHOOL

75 First Street • Lodi, New Jersey 07644 · Phone: (973) 478-8662 • Fax: (973) 478-0358

PARENT/LEGAL GUARDIAN

PERMISSION TO RELEASE & EXCHANGE CONFIDENTIAL INFORMATION

I hereby authorize an exchange of Information to occur between the School Health Services nursing staff of the **above** agency and:

NAME: *All teachers and staff of TJMS* PHONE: *973-478-8662*

Address: *75 First St. Lodi, NJ 07644*

regarding: O any or all information

● specific Information regarding: Allergies

contained in the record of:

NAME _____ DATE OF BIRTH _____

OTHER NAMES USED _____ SCHOOL _____

I further authorize the School Health Services nursing staff to share any health Information pertinent to my child's school progress with school personnel and/or other health care providers to which my child may be referred.

The reason for disclosure is:

● patient care O medical **review** O other (specify) _____

This authorization is in effect for one calendar year from today: _____

Date

I consent to release of the above information. I understand that use of this information for any reason other than the expressed reason stated above is prohibited and that disclosure of this information to other parties is strictly prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon.

I completed this form because I am: (please cheek one) O Client O Legal Guardian O Parent

SIGNATURE OF PARENT/LEGAL GUARDIAN _____ DATE _____
