CONTRACT FOR STUDENTS SELF-CARRY OF EPI-PEN®

STUDENT

☐ I plan to keep my Epi-Pen® with me at school rather than in the school health office.

☐ I agree to use my Epi-Pen® in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office immediately if my Epi-Pen® has been used.

☐ I will not allow any other person to use my Epi-Pen®.

Student's Signature _____ Date _____

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.

☐ It has been recommended to me that a back-up Epi-Pen® be provided to the Health Office for emergencies.

☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the treatment plan.

Parent's Signature _____ Date _____

SCHOOL NURSE

☐ The above student has demonstrated correct technique for Epi-Pen® use, an understanding of the physician order for emergency use of the Epi-Pen®.

☐ School staff that has the need to know about the student's condition and the need to carry medication has been notified.

Registered Nurse's Signature _____ Date _____

HEALTH CARE PLAN
SEVERE ALLERGY TO:_

Student Name: School:
Birthdate: _____

Emergency Treatment

If student experiences mild symptoms:
several hives, itchy skin, itchy red watery eyes or nasal symptoms
OR if an ingestion is suspected:

Treatment:

1. Send student to health office **ACCOMPANIED.**
2. **Give** (amount and dosage:) **of** (antihistamine) **by mouth.**
3. Contact the parent or emergency contact person.
4. **If exposed - Have child wash face, hands and exposed area.**
5. Stay with the student; keep student quiet, monitor symptoms, until parent arrives.
   Watch student for more serious symptoms listed below.

Special Instructions:

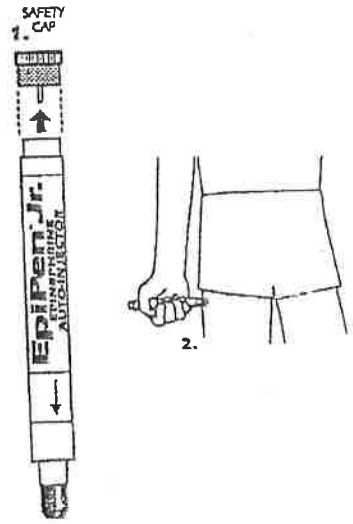
Symptoms that progress and can cause a life threatening reaction:

- *Hives spreading over the body.*
- *Wheezing, difficulty swallowing/ breathing, swelling (face, neck), tingling/swelling of tongue.*
- *Vomiting*
- *Signs of shock (extreme paleness/gray color, clammy skin, etc.), loss of consciousness.*

Treatment:

1. **Give:** ☐ **Epi-Pen Jr.®** (under 66lbs) **OR** ☐ **Epi-Pen®** (66lbs & over) **immediately**

   Place against upper outer thigh, through clothing if necessary.
2. **Call 911** (or local emergency response team) immediately.
3. Epi-pen® only lasts 20-30 minutes.
   ****Paramedics should always be called if Epi-Pen® is given****
4. Contact parents or emergency contact person. If parents unavailable, school personnel should accompany the child to the hospital.



Directions for use of Epi Pen®:

1. Pull off gray cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, and then remove.
5. Discard Epi Pen® in impermeable can and dispose per school policy, or give to emergency care responder. (Do not return to holder)

It is understood by parents and health care provider(s) that this plan may be carried out by school personnel other than the School Nurse Consultant (RN). A RN is to be responsible for delegation of this Health Care Plan to unlicensed persons.

Health Care Provider Authorization (Required):_____ Date:_____

Parent/Guardian Signature (Required): _____ Date:_____

☐ Parent/Guardian Copy ☐Student Copy ☐School Copy ☐Transportation Copy

MY SEIZURE PLAN

Name: _____ **Birth Date**: _____

Address: _____ **Phone**: _____

1st Emergency Contact: _____ **Relation**: _____

Phone(s): _____ **Email**: _____

2nd Emergency Contact: _____ **Relation**: _____

Phone(s): _____ **Email**: _____

SEIZURE INFORMATION

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

TRIGGERS

_____

_____

DAILY SEIZURE MEDICINE

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

OTHER SEIZURE TREATMENTS

Device Type:_____ Model:_____ Serial#:_____ Date Implanted:_____

Diatery Therapy:_____ Date Begun:_____

Special Instructions:_____

Other Therapy:_____

MY SEIZURE PLAN

SEIZURE FIRST AID

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed:_____

WHEN SEIZURES REQUIRE ADDITIONAL HELP

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"AS NEEDED" TREATMENTS (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

CALL 911 OR SEEK EMERGENCY MEDICAL ATTENTION IF ...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed:_____

HEALTH CARE CONTACTS

Epilepsy Doctor:_____ Phone: _____
Nurse/Other Health Care Provider:_____ Phone: _____
Preferred Hospital:_____ Phone: _____
PCP or Other Doctor:_____ Phone: _____
Pharmacy:_____ Phone: _____

SPECIAL INSTRUCTIONS: _____

_____

My signature _____ **Provider signature**_____ **Date** _____

 A service of the Epilepsy Foundation

HEALTH CARE PLAN
SEVERE ALLERGY TO:_

Student Name: School:

Birthdate: _____

Allergies (food, insects, medication, etc): **Reaction:**

_____ _____

_____ _____

_____ _____

Diet Restrictions:

For food allergies: ☐ parents will monitor school lunch menus or provide food and communicate with school personnel

☐ student will self monitor food choices

☐ teacher will assist child unable to self select food choices

☐ other

Medications used on a daily basis (include doses):

HOME: _____

SCHOOL:

REMINDER: School personnel must take Epi-Pen® or any other medication on all field trips.
Make sure phone is close by, if needed. Keep Epi-Pen® at room temperature.
DO NOT FREEZE, refrigerate or keep in extreme heat.

Pertinent Health History (as completed by School Nurse):

EMERGENCY INFORMATION

Parent/Guardian	Number in order of preference	Number in order of preference
Home Phone:		
Cell Phone:		
Work Phone:		
Pager Number:		
Home Address:		
Emergency Contact:	**Name:**	**Phone:**
Emergency Contact:	**Name:**	**Phone:**

Health Care Provider who should be called regarding the allergic reaction:

Name: _____
Phone: _____
Hospital Preference:

If ____ experiences a change in health condition (such as a change in medication or hospitalization) please contact the School Nurse (RN) so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well being while at school or during school related activities.

Parent/Guardian Signature: (Required)_____ Date _____

School Nurse (RN) Signature: (Required)_____ Date _____

Administrator Signature: (Preferred)_____ Date _____

☐ Parent/Guardian Copy ☐Student Copy ☐School Copy ☐Transportation Copy