BUCKS COUNTY TECHNICAL HIGH SCHOOL
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School Nurses
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ALLERGY MANAGEMENT PLAN

Student's Name _____ Grade_____

Physician's Name _____ Physician's Telephone Number _____

Indication for use of EpiPen: Allergens and type of allergic reactions:

_____

_____

Last time EpiPen medication was administered: _____

All Current Medications:

_____

_____

Medications To Be Given at School (if any) **To be completed by physician

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Physician's direction for administration and follow-up care, including potential adverse reactions, after the use of an EpiPen. ** To be completed by physician

_____

_____

****Student is competent and able to carry and self-administer allergy medication. Yes No**

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Allergy Emergency Action: *It is recommended that students keep a back-up EpiPen in the Nurses Office.*

EpiPen Self Administration

Please complete this form if it is necessary for your student to carry an EpiPen in school.
*It is recommended that a back-up EpiPen be kept in the Nurses Office.

Student's Name _____ Grade _____

To self administer in school, the student must be able to:

1. Respond and visually recognize his/her name,
2. Identify his/her medication,
3. Demonstrate the proper technique for EpiPen self administration,
4. Demonstrate a responsible and cooperative attitude in all aspects of EpiPen self administration.
5. Acknowledge the importance of reporting the use of the EpiPen to the school nurse, indicating willingness to comply.

_____	_____	_____
Name of Medication	Dosage	Frequency

As the parent/guardian of the above named student, I certify that my child is capable of meeting the above criteria. I relieve the school and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use or sharing of the EpiPen medication or other violation of the medication policy will result in the immediate confiscation of the inhaler and loss of privileges to self administer.

_____	_____
Date	Parent/Guardian Signature

I agree to be solely responsible for my EpiPen and follow the directions for its use as ordered by my physician as well as the school's medication policy. I will report to the School Nurse with an onset of symptoms or immediately after use.. I am aware that any abuse of this privilege will result in the confiscation of my medication.

_____	_____
Date	Student Signature

****Please Note:** If the parent/guardian has not signed the competency statement above, the student ***must*** demonstrate competency to the School Nurse as verified below.