

Upper Moreland Township School District

Dear Parent/Guardian of: \_\_\_\_\_

Any student with a diagnosis of:

- SEVERE FOOD ALLERGY, \_\_\_\_\_
- SEVERE INSECT ALLERGY \_\_\_\_\_
- ASTHMA \_\_\_\_\_
- DIABETES \_\_\_\_\_
- SEVERE ALLERGY \_\_\_\_\_ unknown trigger

AND any student who may use one of the following medications while at school: **Oral antihistamines; Injectable Epinephrine; Inhalers; Nebulizer treatments, is required** to have an Action Plan on file in their students Health Record. Action Plans require yearly updates.

In order to ensure appropriate Medical Treatment for your child, please complete the attached Action Plan; have your Health Care Provider update the Medical Information and SIGN the form, (if available, your Health Care Provider may also use their own office Action Plan.)

Return the completed Action Plan to the School Nurse.

Thank you so much for your cooperation to this very important matter.

UMTSD Nursing team



**PLACE  
PICTURE  
HERE**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

**THEREFORE:**

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

**FOR ANY OF THE FOLLOWING:  
SEVERE SYMPTOMS**



**LUNG**

Shortness of breath, wheezing, repetitive cough



**HEART**

Pale or bluish skin, faintness, weak pulse, dizziness



**THROAT**

Tight or hoarse throat, trouble breathing or swallowing



**MOUTH**

Significant swelling of the tongue or lips



**SKIN**

Many hives over body, widespread redness



**GUT**

Repetitive vomiting, severe diarrhea



**OTHER**

Feeling something bad is about to happen, anxiety, confusion

**OR A  
COMBINATION**  
of symptoms  
from different  
body areas.



- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

**MILD SYMPTOMS**



**NOSE**

Itchy or runny nose, sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives, mild itch



**GUT**

Mild nausea or discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

**MEDICATIONS/DOSES**

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

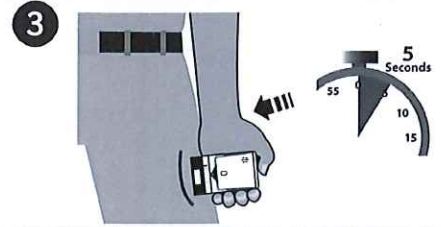
Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_



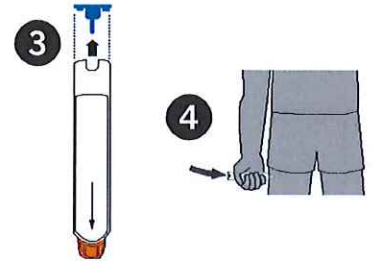
**HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO**

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



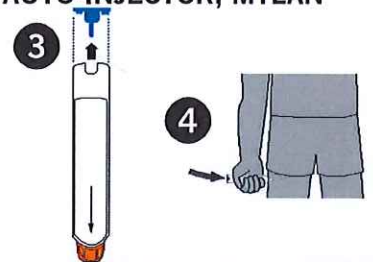
**HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN**

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



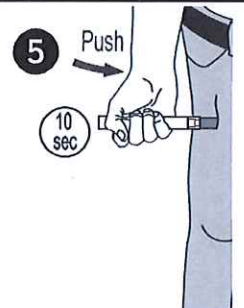
**HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN**

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



**HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES**

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



**ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:**

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

**EMERGENCY CONTACTS — CALL 911**

RESCUE SQUAD: \_\_\_\_\_  
DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_  
PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

**OTHER EMERGENCY CONTACTS**

NAME/RELATIONSHIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
NAME/RELATIONSHIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_

SCHOOL DISTRICT OF UPPER MORELAND TOWNSHIP  
2900 TERWOOD ROAD  
WILLOW GROVE, PA

USE OF MEDICATION PERMISSION FORM

The Board of School Directors of Upper Moreland Township, in accordance with the guidelines from the Pennsylvania Department of Education and Pennsylvania Department of Health, has revised Policy 210 and has adopted Policy 210.1 concerning the administration of medication in school. For the purposes of these policies, "Medication" includes Prescription and Over the Counter medicines. The policy states that all medication brought to school must be in the original labeled container and must be delivered to school by the parent/guardian. All medications are to be kept in the nurse's office unless otherwise specified by the child's Health Care Provider. Every attempt should be made to dispense medication at home; however, any medication deemed necessary for the continued treatment of medical conditions will be given during school hours as prescribed by the child's Health Care Provider.

**Prescription Medication:**

-A written/electronic Prescription from the child's Health Care Provider is required in order to dispense Prescription medication at school. This form can also be used by your Health Care Provider.

-All Prescription medication must be brought to school in the labeled Pharmacy container.

**Over the Counter Medication:**

-A written/electronic Prescription from your child's Health Care Provider is required in order to dispense Over the Counter medications at school. This form can also be used by your Health Care Provider.

-All Over the Counter medications supplied by parent/guardian must be brought to school in the labeled container.

**ATTENTION PARENT/GUARDIAN:** Your signature and the signature of your Health Care Provider is required on the lower portion of this form. By providing these signatures, you are giving permission for administration of medication to your child during school hours. Please fill in all sections to ensure that medication is given correctly.

---

School District of Upper Moreland Township  
PERMISSION FOR MEDICATION TO BE GIVEN AT SCHOOL

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

**(Inhalers, Epi-pens, Insulin pumps and Insulin injections require Action Plan or Treatment Plan attached for use in school)**

Time to be Given \_\_\_\_\_ Length of Time \_\_\_\_\_

Reason for Medication \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Permission to carry Inhaler: yes no MD/DO/NP signature \_\_\_\_\_

Permission to carry Epi-pen: yes no MD/DO/NP signature \_\_\_\_\_

---

Permission for School Nurse to administer Over the Counter:

Acetaminophen yes no

Ibuprofen yes no

Antacid (9th-12<sup>th</sup> only) yes no

**\*\*\* PLEASE NOTE:** Physicians orders and Parent Permission are valid for the current school year and MUST be updated each year.