



ST. ALOYSIUS
CATHOLIC SCHOOL

4001 Mimosa Street • Baton Rouge, LA 70808 • Telephone 225-383-3871 • Fax 225-383-4500 • school.aloysius.org

St. Aloysius Catholic School has been recognized as a National Blue Ribbon School of Excellence by the U.S. Department of Education.

Epinephrine Auto-injector/Nasal Spray

Student Name: _____ DOB: _____ Grade: _____

Parents/Guardians,

All antihistamines and epinephrine (injector or nasal spray) must be brought to the school by an adult and be provided in the original container. Prescription labels should have the name of doctor, name of the pharmacy, name of the student, name of the medication, dosage, and specific instructions

Please initial those that apply to your student:

- ____ (initial) I have notified my child's teacher of my child's allergies ____ (date)
- ____ (date) I have informed my child's bus driver (N/A if your child does not ride bus)
- ____ (initial) I have informed the cafeteria and completed the cafeteria form
- ____ (initial) When my child is in a club, staying after school, involved in sports or other activity outside of the building, I will inform that event coordinator
- ____ (initial) I have supplied the school nurse with completed and signed medication orders (5 pages)
- ____ (initial) TWO Epinephrine auto-injector or nasal spray devices with valid expiration dates was supplied to the school nurse to administer as needed. Exp. date ____
- ____ (initial) I decline to have an epinephrine device at St. Aloysius School and have provided a letter from my child's pediatrician stating that it is not required at school

Parent/Guardian PRINT NAME

Parent/Guardian signature

Date

Erin G. Candilora, *Principal* ♦ Fr. Michael J. Alello, *Pastor*



Name: _____ D.O.B.: _____

Allergic to: _____

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

History of anaphylaxis: Yes No

**PLACE
PICTURE
HERE**

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

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.



- ADMINISTER EPINEPHRINE IMMEDIATELY.**
- 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.

ADDITIONAL PHYSICIAN COMMENTS

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 AND CALL 911.

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

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine and call 911.

If this box is checked by the child's physician, the child has an extremely severe allergy to _____ and should be given epinephrine at the first sign of any symptoms, even if mild.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM (intramuscular) 0.15 mg IM
 0.3 mg IM 1 mg IN (intranasal) 2 mg IN

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

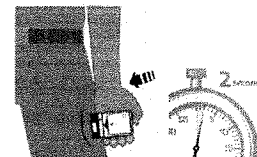
Other (e.g., inhaler-bronchodilator if wheezing): _____

Patient may self-carry Patient may self-administer



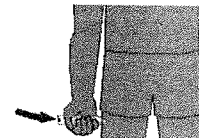
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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



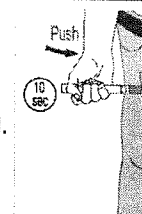
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, VIATRIS AUTO-INJECTOR, VIATRIS

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. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



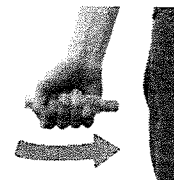
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. 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.

HOW TO USE NEFFY® (EPINEPHRINE NASAL SPRAY)

1. Remove neffy from packaging. Pull open the packaging to remove the neffy nasal spray device.
2. Hold device as shown. Hold the device with your thumb on the bottom of the plunger and a finger on either side of the nozzle. Do not pull or push on the plunger. Do not test or prime (pre-spray). Each device has only 1 spray.
3. Insert the nozzle into a nostril until your fingers touch your nose. Keep the nozzle straight into the nose pointed toward your forehead. Do not point (angle) the nozzle to the nasal septum (wall between your 2 nostrils) or outer wall of the nose.
4. Press plunger up firmly until it snaps up and sprays liquid into the nostril. Do not sniff during or after the dose is given. If any liquid drips out of the nose, you may need to give a second dose of neffy after checking for symptoms. Call 911 immediately after first use.
5. If symptoms don't improve or worsen within 5 minutes of initial dose, administer a second dose into the same nostril with a new neffy device.



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: _____

NAME/RELATIONSHIP: _____ PHONE: _____

STATE OF LOUISIANA MEDICATION ORDER

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

(In most instances, medications will be administered by unlicensed personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name _____ Birthdate _____

School _____ Grade _____

Parent or Legal Guardian Name (print): _____

Parent or Legal Guardian Signature: _____ Date: _____

(Please note: A parental/legal guardian consent form must also be filled out. Obtain from the school nurse.)

PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Relevant Diagnosis(es): _____
2. Student's General Health Status: _____
3. Medication: _____
4. Strength of medication: _____ Dosage (amount to be given): _____

Check Route: By mouth By inhalation Other _____

Frequency _____ Time of each dose _____

School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.

5. Duration of medication order: Until end of school term Other _____
6. Desired Effect: _____
7. Possible side-effects of medication: _____
8. Any contraindications for administering medication: _____
9. Other medications being taken by student when not at school:

10. Next visit is: _____

Prescriber's Name (Printed) _____ Address _____ Phone and Fax Numbers _____

Prescriber's Signature _____ Credential (i.e., MD, NP, DDS) _____ Date _____

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medications orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE.

Inhalants / Emergency Drugs

Release Form for Students to be Allowed to Carry Medication on His/Her Person

Use this space only for students who will self-administer medication such as asthma inhaler.

1. Is the student a candidate for self-administration training? Yes No
2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? Yes No
3. If training has not occurred, may the school nurse conduct a training program? Yes No

Licensed Provider's Signature _____ Date _____

OVER

St. Aloysius Catholic School

Parent/Legal Guardian Consent for Medication Administration at school

NOTE: State of Louisiana Medication Order Form is also required for medications to be administered at school.

Name of Student: (print) _____ Birth date: _____ Homeroom: _____
Name of Parent/Guardian: _____ Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
List ALL medications to be given at school: _____
List ALL allergies for this student: _____
Other medications taken at home: _____
Special instructions for giving medication: _____

1. Have you received and understand the SAS School Medication Policy? Yes _____ No _____
2. Do you give permission for the school nurse to share with designated unlicensed personnel information about your child relative to medication administration, as the nurse deems necessary? Yes _____ No _____
3. Do you understand that you may retrieve the medication from school at any time? Yes _____ No _____
4. Do you understand that medication will be destroyed if not picked up within one week following the end of the school term, or when medication has been discontinued? Yes _____ No _____
5. Have you administered a dose at home and observed your child for 24 hours for an adverse reaction, before the medication can be given at school? Yes _____ No _____
6. Do you consent for a teacher or other non-licensed personnel of SAS to administer medication(s) on a field trip? (Please notify the school nurse at least one day prior to a field trip.) Yes _____ No _____

Answers to the above questions must be "yes" before medication can be administered at school.

Complete the following section ONLY if the Physician Medication Order (Part 3) is completed, AND you wish for your child to CARRY HIS/HER OWN emergency medications (inhaler/epinephrine) at school:

1. Do you give permission for your child to carry and self-administer emergency medication(s) if the school nurse determines that it is safe and appropriate in the school setting? Yes _____ No _____
2. Do you believe that your child is sufficiently responsible and informed to self-administer his/her own medication? Yes _____ No _____
3. Do you assume responsibility for your child's actions regarding his/her self-management of medication in the school setting? Yes _____ No _____
4. Has your physician completed Part 3 of the Physician Medication Order? Yes _____ No _____

Answers to the above questions must be "yes" before SAS will allow a student to carry emergency medications. The state of Louisiana laws ONLY allows self-administration of EMERGENCY medications. (Inhalers/Epinephrine).

I understand and agree that St. Aloysius Catholic School and its employees are not responsible for any unintentional mistakes or oversights in keeping or giving my child medication. I agree to hold the school employees free and harmless from liability from injuries that might occur as a result of the administration of medication(s) to my child.

Signature of Parent/Guardian

Date