THE JAPANESE WEEKEND SCHOOL OF NEW YORK
THE JAPANESE EDUCATIONAL INSTITUTE OF NEW YORK
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※この用紙は、アレルギー等でエピペンの必要な方のみ提出してください。

EpiPen　Waiver　Form

If your Child has allergies that require the use of an EpiPen, please full out the section below and return to school prior to the start of the school year.
Thank you.

In case my child suffers an allergic reaction during The Japanese weekend school of New York school hours, The Japanese weekend school of New York staff member will administer an antidotal shot via an EpiPen. I will take all responsibility for this action, and will keep up the supply of EpiPens as needed.

____
signature of parent/guardian　（保護者署名）　　　　date(日付)

※（　　）内の項目を〇で囲んで下さい

（　W　・　LI　）校　（　幼年中・幼年長・初等部・中等部・高等部　）

　　年　　組　児童生徒名______________________

保護者氏名______________________

The Japanese weekend school of New York

EpiPen Order Form/Care Plan

Medication Form for Students with Allergic Reactions - To be completed by physician/authorized prescriber

Name: ____________________ Gender: M F School/Grade: ____________________ DOB: ____________

Student Allergies: ____

Known Triggers: ☐ Ingestion ☐ Touch ☐ Sting ☐ Other (list) ____________________

Date of Order: ______________ Order Expires End of School Year **OR** (list date): ______________

Order Valid for Current Year including Summer School ☐ (check box if applies)

Physician/Prescriber Signature: ______________________________ Phone: ______________

Parent/Guardian Signature: ______________________________ Phone: ______________

EpiPen Order

EpiPen Dose: **(Circle one)** .15mg .30mg

Student is able to self-administer: YES NO

Student may carry EpiPen on self: YES NO

(A back-up EpiPen must be kept in Health Room)

Date EpiPen Expires: ____________________

Possible Side Effects: ____________________

Oral Medication Order

Medication: ____________________

Dose: __________ Strength: __________

Frequency: ____________________

Date Medication Expires: __________

Possible Side Effects: __________

____

Student Photo

Administration Choices (please check all that apply):

_______ Administer ____________________ for known or possible ingestion/touch/sting/other (list) ____________________.

(oral medication) of ____

_______ Prior to onset of symptoms

_______ If student develops hives, rash, itchy mouth or other symptom(s) (list) ____________________

_______ After EpiPen is given

_______ Give EpiPen for known or possible ingestion/touch/sting/other __________ of ____________________.

_______ Prior to onset of symptoms

_______ At first sign of any symptoms (see back for list)

_______ Only if student develops throat/lung/heart symptoms or if two or more body systems are involved (see back for list)

Other Instructions: ____

____

Student Name: ______________________ Date: __________

Anaphylaxis Symptoms (by body systems)

Mouth/Nose
- Itching &/or swelling of lips, mouth or tongue
- Nasal congestion
- Runny, sniffling nose
- Sneezing

Throat
- Itching/tightness in throat
- Sore throat; throat clearing
- Hacking cough
- Hoarseness

Gastrointestinal
- Nausea
- Vomiting
- Abdominal cramps
- Diarrhea

** Call 911 as soon as symptoms of anaphylaxis aare observed and the need to administer the EpiPen has been determined

** Call parent after administering EpiPen and contacting EMS services.

Skin
- Hives/wheals covering large areas of the body
- Itchy, red skin/rash
- Perception of feeling itchy all over
- Flushing, itching, burning
- Swelling, especially on face/chest

Lungs
- Difficulty breathing
- Chest tightness/pain
- Cough
- Wheezing
- Shortness of breath

Heart (cardiac)
- Dizziness, fainting
- Shock (drop in blood pressure, thready pulse
- Palpitations
- Unconsciousness

INSTRUCTIONS TO GIVE EPIPEN:
1. Identify student.
2. Remove gray safety cap.
3. Place black tip against outer thigh.
4. Push firmly until you hear injector function (click). Hold in place 10 seconds.
5. Monitor student -Initiate CPR if necessary.
6. Begin CPR if necessary.

Oral Medication Administration

__________ (Medication) __________ (Dose) administered on __________ (Date) at ______ (Time) for ____________________ Symptoms/Reasons __________ Signature

__________ (Medication) __________ (Dose) administered on __________ (Date) at ______ (Time) for ____________________ Symptoms/Reasons __________ Signature

__________ (Medication) __________ (Dose) administered on __________ (Date) at ______ (Time) for ____________________ Symptoms/Reasons __________ Signature

EpiPen **.15mg** or **.30mg** (circle one) was administered on __________ (date) at __________ (time) in **R** **L** (circle one) thigh.
by ______________________ Signature ______________________ Title

__________ Medication __________ Dose was administered on __________ Date at ______ Time by ______________________ Signature/Title