

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○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: <input type="checkbox"/> Ingestion <input type="checkbox"/> Touch <input type="checkbox"/> Sting <input type="checkbox"/> Other (list) _____			
Date of Order: _____		Order Expires End of School Year OR (list date): _____	
Order Valid for Current Year including Summer School <input type="checkbox"/> (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:	_____

<p>Student Photo</p>

Administration Choices (please check all that apply):	
<input type="checkbox"/> Administer _____ <small>(oral medication)</small>	for known or possible ingestion/touch/sting/other (list) _____ of _____
<input type="checkbox"/> Prior to onset of symptoms	
<input type="checkbox"/> If student develops hives, rash, itchy mouth or other symptom(s) (list)	_____
<input type="checkbox"/> After EpiPen is given	
<input type="checkbox"/> Give EpiPen for known or possible ingestion/touch/sting/other _____	of _____
<input type="checkbox"/> Prior to onset of symptoms	
<input type="checkbox"/> At first sign of any symptoms (see back for list)	
<input type="checkbox"/> 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, sniffing 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 are 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 _____