If your Child has allergies that require the use of an EpiPen, please fill 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:  
- [ ] 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: ___________________________

**Administration Choices (please check all that apply):**

[ ] Administer ___________________________ for known or possible ingestion/touch/sting/other (list) ___________________________.

[ ] 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: ___________________________
**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.**

### 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

- **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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Administered On</th>
<th>Date</th>
<th>Time</th>
<th>Symptoms/Reasons</th>
<th>Signature</th>
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### EpiPen .15mg or .30mg (circle one) was administered on _________ (date) at _________ (time) in R L (circle one) thigh.

by

Signature

was administered on _________ at _________ by

Medication Dose Date Time Signature/Title