



GREATER NEW BEDFORD REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL

1121 Ashley Boulevard, New Bedford, MA 02745-2496
Tel. 508-998-3321 Fax 508-995-7268 www.gnbvt.edu

Preparation • Passion • Perseverance

Dear Parent/Guardian,

According to your child's school health record, your child has a **Life-Threatening Allergy**. Enclosed is a packet with instructions and required paperwork for you and your child's medical provider to complete for the start of school. *Please ensure your child's provider completes the required paperwork on or after July 1st of the new school year.* All documents in this packet must be completed and returned along with the prescribed epinephrine auto-injector (e.g., EpiPen/ Auvi-Q) or Neffy on the first day of school. A checklist is enclosed for your convenience.

If your child plans to participate in a fall sport, all paperwork must be submitted to the Nurses' Office prior to the start of the fall sports season, including tryouts. Students will not be permitted to participate in activities outside of the school building without the required paperwork and their prescribed epinephrine auto-injector or Neffy on file.

Please take the time to review this required paperwork for your child, as well as the attached checklist, in detail to ensure completion of all documents, including the FARE form, which must be completed by the physician and signed by you.

If you have any questions regarding this packet, please call the nurse's office at 508-998-3321 ext. 204/205/661/791. Please note the direct fax number to the nurse's office is 508-998-4647.

Thank you,
GNBVT School Nurses

Greater New Bedford Regional Vocational Technical High School is committed to ensuring equal opportunities for all students. The school does not discriminate on the basis of race, color, national origin, genetics, ancestry, limited English proficiency, sex, disability, religion, sexual orientation, gender identity, age, homelessness, immigration status, military status or veteran status in its education programs and activities, including admission to or employment in such programs or activities.

Michael P. Watson
Superintendent-Director

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Proudly Serving the Towns of Dartmouth and Fairhaven and the City of New Bedford



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Life Threatening Allergy Checklist:

All paperwork must be completed on or after July 1st of the new school year. Please ask your child's provider to indicate "YES" for self-carry/self-administration so the student may self-carry and self-administer medication during field trips, placements, co-op, and extracurricular activities, if needed.

Emergency Care Plan (FARE Form) – Required for all students

- Must be completed and signed by parent/guardian
- Please include emergency contacts on page 2
- If the medical provider also completes and signs the Medications/Doses section of the FARE Form, a separate Licensed Prescriber's Medication Order is not required

Licensed Prescriber's Medication Order (*only required if the FARE Form is not completed/signed by the medical provider*)

- Completed and signed by medical provider

Parent/Guardian Authorization for Dispensing Medication

- Completed and signed by parent/guardian

Epinephrine Auto-Injectors (EpiPen/Auvi-Q/generic) or Neffy Epinephrine Nasal Spray

- Two (2) epinephrine auto-injectors or Neffy nasal sprays are required
- One (1) for the student to carry at all times in their backpack
- One (1) to be stored in the Nurse's Office



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



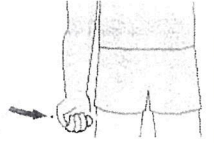
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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 ADRENACLICK®), 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: _____



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Medication Order

(To Be Completed By A Licensed Prescriber – Physician, Nurse Practitioner, or Others Authorized by Chapter 94)

Student's Name:		DOB:		Grade:	
Address:			City:		State: Zip:
Name/Title of Licensed Prescriber:			Business Phone:		Emergency Phone:
Medication:			Dosage:		
Route of Administration:		Frequency:		Time(s) of Administration:	
Please Note: Whenever possible, medications should be scheduled at times other than school hours. Over-the-Counter medications will require a written order to be administered in school.					
Special Directions/Information for Administration:					
Date of Order:			Discontinue Order:		
Diagnosis (If not in violation of confidentiality):					
Any other Medical Condition(s):					
Additional Information:					
1. Special side effects, contra-indications, or possible adverse reactions to be observed:					
2. Other Medications being taken by the student:					
3. The date of the next scheduled visit or when advised to return to the prescriber:					
Consent for self-administration provided the school nurse determines it is safe and appropriate: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Signature of Licensed Prescriber:				Date:	
Comments:					



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Parent/Guardian Authorization for Dispensing Medication

(To Be Completed By Parent/Guardian)

Student's Name:		DOB:		Gender:	
Address:			City:		State: Zip:
Parent/Guardian Name(s):		Home Phone:	Cell Phone:		Work Phone:
Emergency Contact (If Parent/Guardian unavailable):			Telephone:		Relationship:
My child is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all medication the child is receiving, including those given during the school day:					
My child is known to have the following allergies:					
I give permission to have the school nurse/trained personnel give the following medications:					
Prescribed by:			To (Child's Name):		
I give permission for my child to self-administer his/her medication if the school nurse determines that it is safe and appropriate. YES <input type="checkbox"/> NO <input type="checkbox"/>					
I give permission for the school nurse to train designated unlicensed school personnel to administer my child's medication when the school nurse (RN) is not immediately available on field trips or during extracurricular activities. YES <input type="checkbox"/> NO <input type="checkbox"/>					
I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the expiration of the order or by the last day of the school year. I also understand that the school nurse may share, with appropriate school personnel, information relative to the prescribed medication, e.g., adverse effects, as he/she determines necessary for my child's health and safety. (if you object to this, please contact the school nurse).					
Signature of Parent/Guardian:			Date:		Relationship to Student: