Westborough Public Schools

Westborough, MA 01581

MEDICATION ADMINISTRATION

School Year ______________ to _____________

Student ___________________________________ Birthdate ______________ Teacher _________________

* * * * * ***To be completed by Physician or Licensed Prescriber*** * * * * *

ALLERGY TO: ____ History of anaphylaxis: ❒ Yes ❒ No

Allergy documented by: ❒ Prior reaction - date/describe: ____

❒ Allergy testing - date/describe: ____

❒ Other: ____

TYPE OF EXPOSURE RISK: ❒ Ingestion ❒ Skin contact ❒ Inhalation ❒ Other: __________________

DOSAGES: Epinephrine - auto-inject IM (circle one): EpiPen (0.3 mg.) EpiPen Jr. (0.15 mg.)

Antihistamine - medication/dose/route: ____

Other treatment or medication/dose/route: ____

PRESCRIBED TREATMENT — Administer Checked Medication **STAT**

If exposure/ingestion of allergen but ***no immediate symptoms:*** ❒ EpiPen Jr. ❒ EpiPen ❒ Antihistamine

If exposure/ingestion of allergen ***with symptoms:*** ❒ EpiPen Jr. ❒ EpiPen ❒ Antihistamine

Other: ____

Symptoms *may* include: itching, tingling, swelling, tightening of throat, shortness of breath, wheezing, coughing, hives, nausea, vomiting, diarrhea, low BP, cyanosis, fainting.

~ ***If EpiPen is administered, RESCUE SQUAD will be summoned for transport to nearest ER.*** ~
Student will be placed in supine position with legs raised until arrival of ambulance.

AUTHORIZATION

❒ Medication shall be kept with the Extended Day Program Coordinator.

Physician/Licensed Prescriber Signature: _________________________________ Date ________________

Stamp or print: Name ____

Address ____ Phone ___________________

Parent/Guardian Signature: ____ Date ____________________