## Appendix A

**School Request for Prescription (Auto-­‐Injectable Epinephrine)**

The Request for Prescription should be completed, signed and returned to the Physician to be considered for a prescription for the undesignated auto-­‐injectable epinephrine from the Requesting Physician. **Once the prescription has been received, a copy of the prescription should be kept in the Medication Administration Record.**

**School Request for Auto-­‐Injectable Epinephrine Prescription**

**Request for Auto-­‐Injectable Epinephrine Prescription**

**School**:

**Address**:

*(Street) (City) (State) (Zip Code)*

**School Nurse (RN) Contact Name:**

The above named school requests a prescription from Physician for the limited purpose of stocking and administering auto-­‐injectable epinephrine to any student upon the occurrence of an actual or perceived anaphylactic adverse reaction, subject to the following conditions:

* + 1. The school will assure that sufficient school nurses are available to provide proper oversight of the program (minimum of one Registered Nurse licensed to practice in the state of Georgia).
    2. The school has approved policies governing the administration of epinephrine by school personnel.
    3. The unlicensed school personnel authorized to administer epinephrine has completed training in recognizing the symptoms of anaphylactic shock and the correct method of administering the epinephrine auto-­‐injector.
    4. The school nurse will provide a training review and informational update for unlicensed personnel at least twice a year.
    5. When epinephrine is administered, the local emergency medical services system (E-­‐911) shall be notified immediately, followed by notification of the school nurse, student’s parents, or, if the parents are not available, any other designated person(s), and the student’s physician.
    6. There are written procedures, in accordance with any standards established by Physician, for:
       1. proper storage of the epinephrine;
       2. documentation of administration;
       3. notification of administration;
       4. recording receipt and return of medication by the school nurse;
       5. reporting medication errors;
       6. reviewing any incident involving administration of epinephrine to determine adequacy of the response and to consider ways to reduce risks for the particular student and the student body in general; and
       7. planning and working with the emergency medical system to ensure the fastest possible response.

**I certify that I have read and agree to the above and all requirements to the administration of epinephrine and that the information provided in this request is accurate.**

**PHYSICIAN** (print name)

**Signature**: Date:

*Address*

*(City)*

*(State)*

*(Zip Code)*

*Telephone*

*Fax*

*Email Address*

**Principal/Headmaster** (print name)

**Signature**: Date:

*Address*

*(City)*

*(State)*

*(Zip Code)*

*Telephone*

*Fax*

*Email Address*

*School Nurse (RN) Contact (Please print name)*

*Address*

*(City)*

*(State)*

*(Zip Code)*

*Telephone*

*Fax*

*Email Address*

## Appendix B

**School Request for Prescription (Albuterol/Levalbuterol)**

Schools or school systems may choose to adopt use of the LEA Request for Prescription form within their district. The Request for Prescription should be completed, signed and submitted to the Licensed Clinician for the undesignated stock Albuterol/Levalbuterol. **Once the prescription has been received, a copy of the Prescription should be kept in the Medication Administration Record.**

**School Request for Albuterol/Levalbuterol Prescription**

**Request for Albuterol/Levalbuterol Prescription**

**Request (check one): □Nebulizer Solution □ Metered Dose Inhaler**

**School Name**:

**Address**:

*(Street) (City) (State) (Zip Code)*

**School Nurse or Designee Contact Name:**

**Request Submitted To:**

**Name of Practice:**

**Physician/Clinician Name:**

The above named school requests a prescription from Physician for the limited purpose of stocking and administering albuterol or levalbuterol to any student upon the occurrence of an actual or perceived respiratory distress, subject to the following conditions:

1. The school will assure that sufficient school nurses are available to provide proper oversight of the program (minimum of one Registered Nurse licensed to practice in the state of Georgia).
2. The school has approved policies governing the administration of albuterol or levalbuterol by school personnel.
3. The unlicensed school personnel authorized to administer albuterol or levalbuterol have completed training in recognizing the symptoms of respiratory distress and the correct method of administering albuterol or levalbuterol...
4. The school nurse will provide a training review and informational update for unlicensed personnel at least twice a year.
5. When albuterol or levalbuterol is administered, the local emergency medical services system (E-­‐911) shall be notified immediately, followed by notification of the school nurse, student’s parents, or, if the parents are not available, any other designated person(s), and the student’s physician.
6. There are written procedures, in accordance with any standards established by Physician, for:
   1. proper storage of the albuterol or levalbuterol;
   2. documentation of administration;
   3. notification of administration;
   4. recording receipt and return of medication by the school nurse;
   5. reporting medication errors;
   6. reviewing any incident involving administration of albuterol or levalbuterol to determine adequacy of the response and to consider ways to reduce risks for the particular student and the student body in general; and
   7. planning and working with the emergency medical system to ensure the fastest possible response.

**I certify that I have read and agree to the above and all requirements to the administration of albuterol or levalbuterol**

**and that the information provided in this request is accurate.**

**PHYSICIAN** (print name)

**Signature**: Date:

*Address*

*(City)*

*(State)*

*(Zip Code)*

*Telephone*

*Fax*

*Email Address*

**Principal/Headmaster** (print name)

**Signature**: Date:

*Address*

*(City)*

*(State)*

*(Zip Code)*

*Telephone*

*Fax*

*Email Address*

*School Nurse (RN) Contact (Please print name)*

*Address*

*(City)*

*(State)*

*(Zip Code)*

*Telephone*

*Fax*

*Email Address*

## Appendix C

**Sample Memorandum of Agreement (Anaphylaxis)**

A school or school system may choose to use a Memorandum of Agreement if a formal agreement is preferred or requested by the licensed provider to define relationship and protocols with respect to the provision of prescription.

## MEMORANDUM OF AGREEMENT BETWEEN

**[PHYSICIAN]**

**AND [SCHOOL]**

**Effective Date: End Date:**

Physician and School enter into this Agreement to support the safe and effective management of allergies and anaphylaxis in the school setting consistent with O.C.G.A. § 20-­‐2-­‐776.2 by stocking and administering auto-­‐injectable epinephrine for use with students experiencing an actual or perceived anaphylactic adverse reaction.

1. Physician agrees to:
   1. Write a prescription in name of school for the stocking of Epinephrine Auto-­‐Injectors to any student believed to be experiencing potentially life-­‐threatening allergic reactions (anaphylaxis) upon receipt of **Request for Prescription Form.**
2. School agrees to:
   1. The school will have sufficient school nurses are available to provide proper oversight of the program (minimum of one Registered Nurse licensed to practice in the state of Georgia).
   2. The school has approved policies governing the administration of epinephrine by school personnel.
   3. The unlicensed school personnel authorized to administer epinephrine will complete training in recognizing the symptoms of anaphylactic shock and the correct method of administering the epinephrine auto-­‐injector. The school nurse will document the training and testing for competency.
   4. The school nurse will provide a training review and informational update for unlicensed personnel at least twice per school year.
   5. The school will maintain a list of school personnel (licensed and unlicensed) authorized and trained to administer epinephrine when a school nurse is not immediately available.
   6. Epinephrine will only be administered in accordance with a written medication administration plan.
   7. When epinephrine is administered, the local emergency medical services system (E-­‐ 911) shall be notified immediately, followed by notification of the school nurse, student’s parents, or, if the parents are not available, any other designated person(s), and the student’s physician.
   8. When epinephrine is administered, the school nurse shall complete Report of Administration and fax to the Physician within 72 hours of administration.
   9. There are written procedures, in accordance with standards established by the Department of Public Health, for:
      1. proper storage of the epinephrine;
      2. development of the medication administration plan;
      3. documentation of administration;
      4. notification of administration;
      5. recording receipt and return of medication by the school nurse;
      6. reporting medication errors;
      7. reviewing any incident involving administration of epinephrine to determine adequacy of the response and to consider ways to reduce risks for the particular student and the student body in general; and
      8. planning and working with the emergency medical system to ensure the fastest possible response.

This Agreement may be canceled or terminated by either of the parties upon thirty days’ written notice.

This day of , .

**Physician** Date

Print/Type Name

**School** Date

Print/Type Name

Title

## Appendix D

**Sample Memorandum of Agreement (Asthma)**

A school or school system may choose to use a Memorandum of Agreement if a formal agreement is preferred or requested by the licensed provider to define relationship and protocols with respect to the provision of prescription.

## MEMORANDUM OF AGREEMENT BETWEEN

**[PHYSICIAN]**

**AND [SCHOOL]**

**Effective Date: End Date:**

Physician and School enter into this Agreement to support the safe and effective management of respiratory distress due to asthma in the school setting consistent with O.C.G.A. § 20-­‐2-­‐776.3 by stocking and administering albuterol or levalbuterol for use with students experiencing actual or perceived respiratory distress.

1. Physician agrees to:
   1. Write a prescription in name of school for the stocking of albuterol or levalbuterol to any student believed to be experiencing respiratory distress upon receipt of **Request for Prescription Form.**
2. School agrees to:
   1. The school will have sufficient school nurses are available to provide proper oversight of the program (minimum of one Registered Nurse licensed to practice in the state of Georgia).
   2. The school has approved policies governing the administration of albuterol or levalbuterol by school personnel.
   3. The unlicensed school personnel authorized to administer albuterol or levalbuterol will complete training in recognizing the symptoms of respiratory distress and the correct method of administering albuterol or levalbuterol. The school nurse will document the training and testing for competency.
   4. The school nurse will provide a training review and informational update for unlicensed personnel at least twice per school year.
   5. The school will maintain a list of school personnel (licensed and unlicensed) authorized and trained to administer albuterol or levalbuterol when a school nurse is not immediately available.
   6. Albuterol or levalbuterol will only be administered in accordance with a written medication administration plan.
   7. When albuterol or levalbuterol is administered, the local emergency medical services system

(E-­‐911) shall be notified immediately, followed by notification of the school nurse, students, parents, or, if the parents are not available, any other designated person(s), and the student’s physician.

* 1. When albuterol or levalbuterol is administered, the school nurse shall complete Report of Administration and fax to the Physician within 72 hours of administration.
  2. There are written procedures, in accordance with standards established by the Department of Public Health, for:
     1. proper storage of the albuterol or levalbuterol;
     2. development of the medication administration plan;
     3. documentation of administration;
     4. notification of administration;
     5. recording receipt and return of medication by the school nurse;
     6. reporting medication errors;
     7. reviewing any incident involving administration of albuterol or levalbuterol to determine adequacy of the response and to consider ways to reduce risks for the particular student and the student body in general; and
     8. planning and working with the emergency medical system to ensure the fastest possible response.

This Agreement may be canceled or terminated by either of the parties upon thirty days’ written notice. This day of , .

**Physician** Date

Print/Type Name

**School** Date

Print/Type Name

Title

## Appendix E

**Emergency Medication Administration Reporting Form**

**EMERGENCY MEDICATION REPORTING FORM**

|  |  |
| --- | --- |
| **SCHOOL DISTRICT:** | **NAME OF SCHOOL:** |
| **ADDRESS (STREET, CITY, STATE, ZIP CODE)** | **CONTACT PERSON COMPLETING FORM** |
| **TELEPHONE:** | **CONTACT E-­‐MAIL:** |
| **DATE OF INCIDENT:** | **TIME OF INCIDENT:**  **A.M.**  **P.M.** |

1. Emergency Medication Administered?
   1. Albuterol/Levalbuterol
   2. Epinephrine Auto-­‐Injector (Epi-­‐Pen)
2. Age of Individual receiving emergency medication:
3. Description of person receiving emergency medication: (circle one only)
   1. Student
   2. Staff Member
   3. Visitor
   4. Other (please specify)
4. Was there any previously known diagnosis of a severe allergy or asthma?
   1. Yes
   2. No
5. If epinephrine administered, document trigger that precipitated allergic episode *(Circle all that apply)*
   1. Food (specific food if known)
   2. Drug (specific drug if known)
   3. Insect (specific insect if known)
   4. Other (please specify)
   5. Not Applicable
6. Location of where symptoms developed: (Check all that apply)
   1. Within school building
   2. On school grounds
   3. Other (e.g., school activity location, field trip location, etc.)
7. Number of doses administered:
8. Type of person administering the emergency medication: (Circle all that apply)
   1. Registered Nurse
   2. Trained Personnel
   3. Student
   4. Other (please specify)

## APPENDIX F

**DOCUMENTATION OF EMERGENCY ADMINISTRATION COMPETENCIES**

Upon completion of written test and demonstration of skills, the qualified trainer is to complete a Documentation of Competencies form. This documentation should

then be maintained for, at least, five years.

# Documentation of Competencies

I have provided orientation, instruction, training and practice opportunities for

to administer **EpiPen® injections** in response to life-­‐threatening systemic allergic reactions (anaphylaxis). I observed the above named person and feel s/he can appropriately perform the tasks above.

Comments:

Date School Nurse/ Qualified Trainer Signature

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* I have been provided adequate orientation, instruction, training and opportunities to practice administering EpiPen® injections in response to life-­‐threatening systemic allergic reactions (anaphylaxis). I feel I have the competencies necessary to provide these services in a safe manner.

Comments:

Date Participant/Staff Signature

# Documentation of Competencies

I have provided orientation, instruction, training and practice opportunities for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to administer **Albuterol by Nebulizer** treatments in response to life-­‐threatening systemic allergic

reactions (anaphylaxis). I observed the above named person and feel s/he can appropriately perform the tasks above.

Comments:

Date School Nurse/ Qualified Trainer Signature

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* I have been provided adequate orientation, instruction, training and opportunities to practice administering EpiPen® injections in response to life-­‐threatening systemic allergic reactions (anaphylaxis). I feel I have the competencies necessary to provide these services in a safe manner.

Comments:

Date Participant/Staff Signature