

AUTHORIZATION FOR MANAGEMENT OF AN ALLERGIC REACTION

This order is valid only for the current school year _____ (Including Summer Session)

Emergency injections are usually administered by non-health professionals such as, a FCPS employee or a FCHD health room technician. These persons are trained by a school registered nurse to give the injection. 911 will be called while the student, health services staff or school staff administers the EPIPEN.

- Prescription medication must be in a container labeled by the pharmacist or health care provider.
- Over-the-counter medication must be in the **original unopened container** with the label intact.
- The provider will be called if a question arises about the student and their medication.
- Thoroughly review reverse side of form before completion.

HEALTH CARE PROVIDER AUTHORIZATION

Name of Student:	Date of Birth:
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Allergies:	Grade:
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Type of Medication/Dosage/Route of Administration: Check appropriate box(es)

Benadryl Elixir 12.5 mg P.O.*
 Benadryl Elixir 25 mg P.O.
 Benadryl Elixir ____ mg P.O.
 EPIPEN 0.15 mg IM**
 EPIPEN 0.3 mg IM
 *P.O. – by mouth **IM - Intramuscularly

Medication is to be Administered: Check appropriate box (es)

Immediately after insect sting (bee, wasp, hornet, yellow jacket)
 Immediately after the ingestion of (specify): _____
 Immediately after contact with (specify): _____
 Unknown etiology: _____

If Benadryl and EPIPEN Are Ordered: Check appropriate box

Give Benadryl and EPIPEN at the same time.
 Give Benadryl, and then wait ____ minutes, if you see (specify specific signs and symptoms i.e. audible wheezing, heart rate above ____, tongue swelling, etc.) _____ then give EPIPEN.

Repeat EPIPEN dose in 15 minutes if EMS has not arrived** Yes No
****For a repeat dose, box must be checked above and parent must provide second EPIPEN for school.**

Possible Medication Side Effects:
 EPIPEN: palpitations, rapid heart rate, sweating, nausea and vomiting
 Benadryl: drowsiness, sedation, sleepiness, dizziness, restlessness, hypotension, palpitations
 Comments: _____

Health Care Provider's Name/Title: (Type or Print)

Telephone:	Fax:	Use for Health Care Provider's Address Stamp
Address:		
Health Care Provider's Signature:	Date:	

PARENT/GUARDIAN AUTHORIZATION

I request designated personnel to administer the medication as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of medication at school.

Parent/Guardian Signature:	Date:
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Parent/Guardian Phone:	Work Phone:
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SELF-CARRY/SELF-ADMINISTRATION AUTHORIZATION/APPROVAL

Self-carry and/or self-administration of prescribed medication must be authorized by the provider and approved by the school registered nurse.

Health Care Provider's authorization for: Self-Carry <input type="checkbox"/> Yes <input type="checkbox"/> No Self-Administration: <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature:	Date:
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School registered nurse approval for: Self-Carry: <input type="checkbox"/> Yes <input type="checkbox"/> No Self-Administration: <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature:	Date:
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Order reviewed and signed by school registered nurse:	Date:
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IMPORTANT INFORMATION FOR PARENTS/GUARDIANS AND PHYSICIANS

1. An acute allergic reaction can be a life-threatening situation. Completion of this form in its entirety is vital so that the EPIPEN can be administered and emergency care implemented.
2. If the student experiences an acute allergic reaction, FCPS personnel will dial 911 while the student/FCHD school health employees/or FCPS staff administers the EPIPEN. Parent/guardian will be notified.
3. An EPIPEN sent to school, must be labeled by a registered pharmacist with the name of the medication, the dose, the name of the health care prescriber, the name of the student, and directions for administration.
4. The parent/guardian should note the expiration date and provide a new EPIPEN prior to expiration.
5. The FCHD school health employees must review and approve these forms in the school prior to administration.
6. The parent/guardian, health care prescriber and school RN must indicate on the reverse side of this form whether the pupil is capable of self-administering the EPIPEN, if needed.

EPIPEN ADMINISTRATION PROCEDURE AND CHECKLIST

Purpose:

To provide immediate access to emergency information and procedure for EPIPEN administration.

Name of Student: _____ Date of Birth: _____

Medication Location: _____

Parent Information:

Mother's Name: _____ Father's Name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Person to be contacted in case of emergency: _____

Phone Number: _____

CHECKLIST

In the event that _____ has an allergic reaction to insect bites, foods, drugs, or other allergies:

___1. "DIRECT SOMEONE TO DIAL 911" - Ask for an ambulance and explain the nature of the emergency.

___2. "DIRECT SOMEONE TO CALL THE PARENT/GUARDIAN."

___3. GIVE MEDICATION.

INJECTION PROCEDURE:

___ Locate area for injection (outer thigh). Use alcohol swab, if available.
If inappropriate to remove clothing, give through clothing.

___ Pull out safety cap.

___ Place black tip on outer thigh.

___ Push hard until injection functions. Leave in place for several seconds.

___4. RECORD MEDICATION NAME, DOSAGE, AND TIME

Medication Name Dosage Time Signature of person administering medication

___5. SEND STUDENT TO MEDICAL FACILITY VIA AMBULANCE with an adult assigned by the principal.

___6. SEND A COPY OF THE DOCUMENTATION of this form to the hospital via the adult assigned to travel with the student.