



Physician Order for Administration of Medication by School Personnel

Epinephrine Injector Authorization

_____ needs to have
Student's Name

(Circle one) EpiPen® EpiPen® Jr. Other _____ available to him/her.

The above named student is allergic to: _____.

FOR SELF-ADMINISTRATION ONLY

Does this student have physician permission to self-administer this medication and to carry this medication on himself/herself?
Yes___ No___

Has this student been trained in the signs and symptoms of minor and major reactions? Yes ___ No ___

Is this student capable of self-administering Epinephrine Injector? Yes ___ No ___

Can this be safely self-administered in the school setting? Yes___ No___

Does this student need the supervision of a designated adult? Yes___ No___

Has the student been trained in the self-administration of the Epinephrine Injector? Yes___ No___

Symptoms

Medication Administration (completed by physician)

If a food allergen has been ingested but no symptoms	___ Epinephrine	___ Antihistamine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth	___ Epinephrine	___ Antihistamine
Skin – Hives, itchy rash, swelling of the face or extremities	___ Epinephrine	___ Antihistamine
GI – Nausea, abdominal cramps, vomiting, diarrhea	___ Epinephrine	___ Antihistamine
Throat * – Tightening of throat, hoarseness, hacking cough	___ Epinephrine	___ Antihistamine
Lung *- Shortness of breath, repetitive coughing, wheezing	___ Epinephrine	___ Antihistamine
Heart *- Thready pulse, low blood pressure, fainting, pale, blueness	___ Epinephrine	___ Antihistamine
Other * - _____	___ Epinephrine	___ Antihistamine
If reaction is progressing (several of the above areas affected, give	___ Epinephrine	___ Antihistamine

*** All the above symptoms can potentially progress to a life-threatening situation. Do not hesitate to call 9-1-1.**

DOSAGE:

Epinephrine: Immediately inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Other _____

Call 9-1-1 and tell them it is life-threatening. Call parent/guardian.

Antihistamine: give _____
Medication/dose/route

Call parent/guardian or emergency contacts if parents are not available.

Other: give _____
Medication/dose/route

Physician's Signature/Stamp

Date

As the parent or legal guardian of the above-named child, I have read the policies pertaining to school personnel administering prescriptive medication and this is your permission to administer the above medication to my child according to the physician's order written above.

Parent/Guardian Signature

Date

For self-administration only:

I have been instructed in the proper use of my prescription Epinephrine Injector and fully understand how to administer this medication. I will not allow another student to use my Epinephrine Injector under any circumstances. I also understand that should another student use my Epinephrine Injector, the privilege of carrying it with me may be revoked. I understand that the school nurse will be notified immediately if I should require the use of my Epinephrine Injector, so that emergency medical care can be obtained.

Student Signature

Date

I hereby request that the above named student, over whom I legal control, be allowed to carry his/her Epinephrine Injector on the KISD campus(es), and be responsible for its use as needed. I understand that the parent/guardian accepts the legal responsibility should the Epinephrine Injector be lost, given or taken by a person other than the student for whom it was prescribed. If this should happen, the privilege of carry the Epinephrine Injector may be revoked. I understand that KISD has no legal responsibility when the above named student administers his/her own medication. I understand that the campus nurse will be notified immediately if the Epinephrine Injector is administered, and emergency medical services will be obtained.

Parent/Guardian Signature

Date

EPIPEN®(EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh (with or without clothing)
4. Hold for approximately 10 seconds
5. Remove and massage the area for 10 seconds.

