Physician Order for Administration of Medication
by School Personnel
Epi-Pen Authorization

____________________________________________________________ needs to have

(circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg 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 EpiPen®? 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 EpiPen®? 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. Twinject™ 0.3 mg
Call 9-1-1 and tell them it is life-threatening. Call parent/guardian.
Twinject™ 0.15 mg

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 Epi-Pen and fully understand how to administer this medication. I will not allow another student to use my Epi-pen under any circumstances. I also understand that should another student use my Epi-pen, 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 Epi-Pen, 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 Epi-Pen 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 Epi-Pen 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 Epi-Pen 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 Epi-Pen is administered, and emergency medical services will be obtained.

____________________________________________________ __________________
Parent/Guardian Signature       Date

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EpiPen® and EpiPen® Jr. Directions
- Pull off gray activation cap.
- Hold black tip near outer thigh (always apply to thigh).
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions
- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold tor 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don’t improve after 10 minutes, administer second dose:
- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.