WASHINGTON EPISCOPAL SCHOOL

Parent's/Guardian's and Physician's Medication Authorization for Emergency Medication – EPIPEN For Management of Acute Allergic Reaction

For Completion by Parent(s)/Guardian(s)

Name of Student _____ School Year_____Grade_____

ALLERGIC TO:_____ **Asthmatic** ☐Yes* ☐No *High risk for Severe reaction

- I understand that I must supply the school with the necessary equipment/supplies.
- I hereby authorize the medication described below to be administered, as directed by my child's physician
- I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- Medication will be kept in the school infirmary and will be sent on school field trips.
- Is your child capable of **self carry/self-administering** the EpiPen, if needed? _____ **yes** _____ **no**

_____ _____ _____
Signature of Parent/Guardian | Parent Emergency Number | Date

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For Completion by Physician

1. Name of medication(s): **EpiPen (Epinephrine Auto Injector)** and **Antihistamine**
   School personnel will be taught by the School Nurse to administer the EpiPen. These individuals are non-medical school staff. Medical orders must be clear and explicit as to when the EpiPen is to be given. These personnel will not make medical judgments or observe for medical symptoms.

2. Medication is to be given: *(check one)*
   _____ **Immediately** after insect sting _____ **Immediately** after ingestion of _____*(specify)*

SYMPTOMS:		**GIVE CHECKED MEDICATION:**	
If 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
Gut	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

3. Route of administration: **Auto injection into anterolateral aspect of the thigh**
4. Dosage of medication: *(check one)* _____EpiPen 0.15 mg. _____ EpiPen 0.3 mg.
   Dosage of Antihistamine:_____
5. Side effects: _____
6. **911 WILL BE CALLED IMMEDIATELY** (upon administration of EpiPen)

_____ _____
Physician's Original Signature (No Stamps) | Date

_____ _____
Physician's Printed Name | Physician's Phone Number