39513036

Howard County Public Schools
Epinephrine Auto-Injector Order Form/Care Plan

Medication Form for Students with Allergic Reactions - To be completed by physician/authorized prescriber

Name: _____ Gender: M F School/Grade:_____ DOB:_____

Student Allergies:

Known Triggers: ☐ Ingestion ☐ Touch ☐ Sting ☐ Other (list) _____

Date of Order: _____ ***Order Valid for Current Year including Summer School, unless otherwise indicated:*** _____

Physician/Prescriber Signature: _____ Phone: _____

Physician/Prescriber: Print Name _____ Fax: _____

Parent/Guardian Signature: _____ Phone: _____

Parent/Guardian: Print Name _____ Cell Phone: _____

Epinephrine Auto-Injector Order

Dose: **(Circle one)** 0.15mg 0.30mg

Student is able to self-administer: YES NO

Student may carry auto-injector on self: YES NO

(A back-up auto-injector must be kept in Health Room)

Date Epinephrine Auto-Injector Expires:

Possible Side Effects: _____

Oral Medication Order

Medication: _____

Dose: _____

Strength: _____

Frequency: _____

Date Medication Expires: _____

Possible Side Effects: _____

Student Photo

Administration Choices (please check all that apply):

_____ Administer _____ for known or possible ingestion/touch/sting/other (list) _____.
(oral medication)

_____ Prior to onset of symptoms

_____ If student develops hives, rash, itchy mouth or other symptom(s) (list)_____

_____ After Epinephrine Auto-injector is given

_____ Give Auto-Injector Epinephrine for know or possible ingestion/touch/sting/other _____ of _____.

_____ Prior to onset of symptoms

_____ At first sign of any symptoms (see back for list)

_____ Only if student develops throat/lung/heart symptoms or if two or more body systems are involved (see back for list)

Other Instructions: _____

_____

_____

_____

Student Name: _____ DOB: _____ Date: _____

39513036 (back)

Anaphylaxis Symptoms (by body systems)

Mouth/Throat	Nose/Eyes/Ears	Gastrointestinal
•Itching, tingling, or swelling of lips, tongue, or mouth •Blue/grey color of lips •Hacking cough •Tightening of throat •Hoarseness •Difficulty swallowing	•Runny nose, itchy nose •Redness and/or swelling of eyes •Throbbing in ears	•Nausea •Abdominal cramps •Vomiting •Diarrhea

** **Call 911** as soon as symptoms of anaphylaxis are observed and the need to administer the Epinephrine Auto-Injector has been determined

** **Call parent** after administering Epinephrine and contacting EMS services.

Skin	Lungs	Heart
•Facial flushing •Hives and/or generalized itchy rash •Swelling of face or extremities •Tingling •Blue/grey discoloration	•Shortness of breath •Wheezing •Short, frequent, shallow cough •Difficulty breathing	•Thready or unobtainable pulse •Low blood pressure •Rapid pulse, palpitations, fainting, dizziness •Pale, blue/grey color of lips or nail bed

INSTRUCTIONS TO GIVE EPINEPHRINE:

1. Identify student.
2. Remove safety cap.
3. Place tip against outer thigh
4. Push firmly until you hear injector function (click) and hold in place according to manufacturer's directions.
5. Monitor student -Initiate CPR if necessary.
6. Begin CPR if necessary.

Mental	Other
•Uneasiness •Agitation •Unconsciousness •Feeling of doom	•Any other symptom specific to an individual's response to a specific allergen

Oral Medication Administration

_____ _____ administered on _____ at _____ for _____ _____
(Medication) (Dose) (Date) (Time) Symptoms/Reasons Signature

_____ _____ administered on _____ at _____ for _____ _____
(Medication) (Dose) (Date) (Time) Symptoms/Reasons Signature

_____ _____ administered on _____ at _____ for _____ _____
(Medication) (Dose) (Date) (Time) Symptoms/Reasons Signature

Epinephrine **0.15mg** or **0.30mg** (circle one) was administered on _____ (date) at _____ (time) in the **R** **L** (circle one) thigh.

by _____ _____
Signature Title

_____ _____ was administered on _____ at _____ by _____
Medication Dose Date Time Signature/Title