Authorization to Give Emergency Medication: Epi-Pen

Medication will be given at school only with written permission from the child's parent or legal guardian. Emergency medications must have written permission from the Health Care Provider to administer. Signed permission will expire at the end of the school year.

Student's Name:_____ Date of Birth:_____

☐ **Check the box if your child wears medical identification. Description:_____**

If exposure to allergen occurs activate the following EMERGENCY PLAN OF ACTION:

EMERGENCY PLAN OF ACTION

1. Administer emergency medication. Allergen (list what child is allergic to)_____
Medication:_____
Dosage:_____
Route:_____
2. Call EMS
3. Notify school personnel trained in CPR/First Aid to stay with student and initiate CPR if needed prior to EMS arrival.
4. Notify Parent/Guardian.
5. If child needs to be transported by EMS, a parent or school representative will meet student at the hospital.

*** DO NOT HESITATE TO ADMINISTER MEDICATION AND CALL EMS FOR ASSISTANCE!!!!!

If exposure to known allergen is uncertain, continuously observe student for signs and symptoms of an allergic reaction such as:

Systems:		Symptoms:
Mouth	-	Itching and swelling of the lips, tongue or mouth
Throat	-	Itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin	-	Hives, itchy rash, and/or swelling about the face or extremities
Stomach	-	Nausea, abdominal cramps, vomiting and/or diarrhea
Lungs	-	Shortness of breath, repetitive coughing, and/or wheezing
Heart	-	Low and weak heart rate, "passing out"

***THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!**

Epi-pen should be: ☐ kept with child ☐ kept in front office ☐ Available during transportation

This student is both capable and responsible for self-administering this medication: ☐ yes or ☐ no

Signature of MD, ARNP, or PA_____Date:_____

Primary Care Provider_____

Address_____

Phone_____

I give permission for myself/my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of the school or health department as a result of administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the request for medication to be followed. My signature will give permission for exchange of verbal and written communication between the Health Care provider and the school nurse regarding my child's medical regime. I hereby give my authorization and consent to trained school personnel to give prompt treatment, as specified about under Emergency Plan of Action, to my child.

Signature of Parent/Guardian_____Date_____

Home Phone_____Work Phone_____

Emergency contact name_____Phone _____

For Office Use only: Expiration Date:_____Date Parent Notified:_____

New Expiration Date:_____ Notes on back if needed