

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

39513036

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
<ul style="list-style-type: none"> •Itching, tingling, or swelling of lips, tongue, or mouth •Blue/grey color of lips •Hacking cough •Tightening of throat •Hoarseness •Difficulty swallowing

Nose/Eyes/Ears
<ul style="list-style-type: none"> •Runny nose, itchy nose •Redness and/or swelling of eyes •Throbbing in ears

Gastrointestinal
<ul style="list-style-type: none"> •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
<ul style="list-style-type: none"> •Facial flushing •Hives and/or generalized itchy rash •Swelling of face or extremities •Tingling •Blue/grey discoloration

Lungs
<ul style="list-style-type: none"> •Shortness of breath •Wheezing •Short, frequent, shallow cough •Difficulty breathing

Heart
<ul style="list-style-type: none"> •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
<ul style="list-style-type: none"> •Uneasiness •Agitation •Unconsciousness •Feeling of doom

Other
<ul style="list-style-type: none"> •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 _____

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