TOWN OF FAIRFIELD HEALTH PROGRAM
MEDICATION AUTHORIZATION FOR STUDENT WITH SEVERE ALLERGIC REACTION (FOOD, INSECT, LATEX, ENVIRONMENTAL, OTHER)

Name of Student_____Date of Birth_____

Specific Allergen_____

Please prescribe two auto-injectors for child to have in school if repeat dose is ordered.

A. Epipen Administration (CHOOSE EITHER #1 or #2)

1. **Administer epinephrine immediately** if child knowingly and/or suspects he/she was exposed to the allergen.
   a. Check one: □ Epinephrine 0.3mg IM or SC □ Epinephrine 0.15mg IM or SC
   □ Epipen Auto-Injector 0.3 mg □ Epipen Jr. Auto-Injector 0.15mg
   □ AUVI-Q auto injector 0.3mg □ AUVI-Q auto injector 0.15mg
   b. Side-effect/plan for management _____

2. **Administer epinephrine if symptoms of anaphylaxis occur.**
   a. Check one: □ Epinephrine 0.3mg IM or SC □ Epinephrine 0.15mg IM or SC
   □ Epipen Auto-Injector 0.3 mg □ Epipen Jr. Auto-Injector 0.15mg
   □ AUVI-Q auto injector 0.3mg □ AUVI-Q auto injector 0.15mg
   b. Side-effects/plan for management _____

____**Repeat x 1 in 10 minutes as needed for symptoms of allergic reaction.**

CALL 911 WHENEVER EPINEPHRINE IS ADMINISTERED.

B. Please complete if an Antihistamine is part of the treatment plan for this student.

1. Drug name (**Brand and Generic**) _____
2. Dose _____
3. Route _____
4. Frequency _____
5. Administer (check one)
   ____ immediately following administration of epinephrine (see above).
   ____ for non-threatening allergic reaction i.e., rash. Continue to observe for symptoms of anaphylaxis. If symptoms progress administer epinephrine.

Side-effects/plan for management _____

Students may self-administer medications(s)___ Epinephrine Auto Injector ____Antihistamine.

Self-administration means that the student will carry and administer his/her medication(s) without assistance.

Duration of Order(s): from _____to _____(date)

_____M.D./D.O./D.D.S./A.P.R.N./P.A./O.D.
Signature Date

_____
Address Telephone Fax