Physician's Medication Authorization Form for the Emergency Administration of Auto-Injectable Epinephrine – For Management of Acute Allergic Reaction

THOROUGHLY REVIEW ENCLOSED AUTO-INJECTABLE EPINEPHRINE ADMINISTRATION INFORMATION

SECTION 1 - *For Completion by Parent(s) / Guardian(s)*

Student's Name: _____ School: _____ School Year: _____ Grade: _____

1. Do you want the School Nurse / School Health Supervisor to instruct/review instructions in auto-injectable epinephrine administration with your child? ❑ Yes ❑ No
2. Is your child capable of self-administering the auto-injectable epinephrine, if needed? ❑ Yes ❑ No

SECTION 2 - *For Completion by Physician **ONLY***

1. Name of Medication: **AUTO-INJECTABLE EPINEPHRINE**

Anakit will not be accepted at school. Auto-injectable epinephrine will not be accepted for the management of asthma.

Volunteer school personnel will be taught how to administer the auto-injectable epinephrine. Volunteer school personnel are nonmedical school staff. Medical orders must be clear and explicit as to when the auto-injectable epinephrine is to be given. Volunteer school personnel cannot be expected to make medical judgments or observe for medical symptoms to determine when to administer the auto-injectable epinephrine.

2. Reason for auto-injectable epinephrine: **Management of acute allergic reactions***: (Check one)*
   - ❑ Stinging insects (bee, wasp, hornet, yellow jacket).
   - ❑ Ingestion of (specify): _____
   - ❑ Other circumstances (specify): _____
3. Auto-injectable epinephrine is to be given: *(Check one)*
   - ❑ Immediately after an insect sting (bee, wasp, hornet, yellow jacket).
   - ❑ Immediately after ingestion of (specify): _____
   - ❑ Second auto-injectable epinephrine is to be given _____ minutes (specify) after the first auto-injectable epinephrine.
4. Route of administration: **Intramuscularly into anterolateral aspect of the thigh.**
5. Dosage of medication: *(Check one)*
   - ❑ Auto-injectable epinephrine 0.30 mg
   - ❑ Auto-injectable epinephrine Jr. 0.15 mg *(recommended for use for students whose weight is below 66 lbs.)*
6. Possible side effects from auto-injectable epinephrine: _____

_____ _____

Physician's Signature / Date *Physician's Printed Name*

_____

Physician's Phone / Fax

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication for anaphylactic reactions may be authorized by the prescriber and must be approved by the school RN/LPN according to the medication policy.

Prescriber's authorization for self-carry/self-administration of emergency medication: _____

Signature *Date*

School RN/LPN approval for self-carry/self-administration of emergency medication: _____

Signature *Date*

_____ _____

Parent's/Guardian's Signature / Date *Parent's/Guardian's Signature / Date*

_____ _____

School RN's Signature / Date *School LPN's Signature / Date*

THIS MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR