

Epinephrine Order and Emergency Care Plan For Allergy/Anaphylaxis

Student _____ Birthdate _____ School _____ Year _____

Health Care Provider to Complete

Identified life-threatening allergen(s) are: _____

Student has demonstrated use to LHCP and may self-administer the Epinephrine Auto-Injector: Yes No

Physician's order for epinephrine auto-injector 0.15 mg 0.3 mg

1. Administer auto-injector if student is unable or not authorized to self-administer **for suspected or actual exposure to above noted life-threatening allergens(s)**
2. Call 911
3. If other medication (i.e.: antihistamine) is needed, a separate *Authorization for Medication at School* form is required.

Diagnosis of asthma? Yes No (If yes, fill out *Authorization for Medication at School* form, including Asthma Action Plan)

Epinephrine Auto-Injector to be stored: Main Office Student Other: _____

This form must be fully completed to allow for school attendance per RCW 28A.210.320.

If epinephrine auto-injector is not immediately available, call 911.

Symptoms of allergic reaction/anaphylaxis may include:	
Gastrointestinal:	<i>Nausea, stomachache, abdominal cramps, vomiting, diarrhea</i>
Heart:	<i>Passing out, fainting, pale, or bluish skin color</i>
Lung:	<i>Shortness of breath, repetitive coughing, wheezing</i>
Mouth:	<i>Itching, tingling, or swelling of the lips, tongue, or mouth</i>
Skin:	<i>Hives, itchy rash, swelling about the face or extremities</i>
Throat:	<i>Sense of tightness in the throat, hoarseness, hacking cough</i>
General:	<i>Panic, sudden fatigue, chills, fear</i>
Other:	<i>Some students may experience symptoms other than those listed above</i>

Parent/Guardian to Complete

I authorize my child to self-administer and carry their epinephrine auto-injector: Yes No

Medication Authorization: Health Care Provider and Parent/Legal Guardian signatures required:

I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above for a potentially life-threatening condition. I understand that **trained unlicensed school personnel** may be delegated to administer the emergency epinephrine auto-injector.

Health Care Provider (signature) _____ Date _____

Health Care Provider (print name) _____ Phone Number _____

By signing this, I acknowledge that I have read and understand the information on page 2 of this form.

Parent/Legal Guardian signature _____ Date _____

Parent/Legal Guardian- I understand the following:

- I understand that **trained unlicensed school personnel** may be delegated to administer the emergency epinephrine auto-injector.
- This order must be **renewed each school year.**
- It is recommended that my child wear a medical alert identification (i.e. bracelet or necklace).
- For afterschool activities, athletic events, or any school related events outside the regular school-hours parent/legal guardian must make arrangements with the building or program administrator to assure access to epinephrine auto-injector.
- My child qualifies for accommodations and will be placed under Section 504. A copy of rights and information will be provided with the accommodation plan.
- If my child is self-carrying and a backup epinephrine auto-injector is NOT provided to the school, **it is understood that my child is required by law to have it in his/her possession while attending any school sponsored event or activity. The availability of having this emergency medication in my child's possession is solely my child's responsibility and mine.**
- It is my responsibility to make sure that the epinephrine auto-injector(s) is current and unexpired.
- I will update this order if any allergens/conditions have changed.
- The school nurse will instruct the designated staff in the intervention protocol per licensed health care provider's order in the use of the epinephrine auto-injector and signs and symptoms of anaphylaxis.