



Pope John XXIII Middle School-Epi-Pen Delegate Orders

Student's Name: _____ D.O.B: _____ Grade: _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

Step 1: TREATMENT

Symptoms:

Give checked medication: (Determined by Healthcare Provider authorizing treatment)

- If an allergen has not yet caused symptoms: _____ Epinephrine
- **Mouth** – Itching, tingling, or swelling of lips, tongue, mouth _____ Epinephrine
- **Skin** – Hives, itchy rash, swelling of the face or extremities _____ Epinephrine
- **Gut** – Nausea, abdominal cramps, vomiting, diarrhea _____ Epinephrine
- **Throat** † – Tightening of throat, hoarseness, hacking cough _____ Epinephrine
- **Lung** † – Shortness of breath, repetitive coughing, wheezing _____ Epinephrine
- **Heart** † – Weak or thready pulse, low blood pressure, fainting, pale, blueness _____ Epinephrine
- **Other** † – _____ Epinephrine
- If reaction is progressing (several of the above areas affected), give: _____ Epinephrine

† Potentially life-threatening. The severity of symptoms can quickly change.

Epinephrine Auto-Injector (circle one): EpiPen 0.3mg EpiPen Jr. 0.15mg Auvi-Q 0.3mg Auvi-Q 0.15mg

Student can self-administer Epinephrine Auto-Injector (check one): Yes No

Step 2: EMERGENCY CALLS

1. Call 911 PARAMEDICS.....State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Parents: _____ Phone Number: _____
3. Emergency Contact: _____ Phone Number: _____
4. Healthcare Provider: _____ Phone Number: _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.

Parent/Guardian Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

Please use box for Healthcare Provider's Stamp (required)

PARENT AUTHORIZATION:

I request that my child be given the medication described in the manner above at school by the school nurse. Only if authorized by the Healthcare Provider, I request my child be permitted to carry an epinephrine auto-injector and self-medicate when necessary. If carried on his/her person, I will be cognizant of the expiration date and renew the injector when needed. I relieve Pope John XXIII Middle School of any liability which may result from the administration of the above medication to my child or from self-administration when certified by the Healthcare Provider.

Parent/Guardian Signature _____ Date _____