

Meyersdale Area School District

Student Name:

Date of Birth:

School Year:

School Name:

Grade:

Teacher:

Allergy To:

Asthmatic: ☐ YES ☐ NO

STEP 1: TREATMENT – To be completed by Physician

Symptoms:	Give checked Medication (to be determined by Physician)	
If exposure to an allergen occurs, but no symptoms	☐ Epinephrine	☐ Antihistamine
Mouth: itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin: Hives, itchy rash, swelling of face or extremities	☐ Epinephrine	☐ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat: tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lungs: shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart: weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other * Call 911 an Parent	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected)	☐ Epinephrine	☐ Antihistamine

*Potentially Life-threatening, the severity of symptoms can quickly change.

Epinephrine-inject intramuscularly	☐ Epi-Pen 0.3mg	☐ Epi-Pen JR. 0.15 mg
Antihistamine	☐ Benadryl	Dose _____ mg

Repeat Epi-Pen ☐ YES ☐ NO in 15 minutes if EMS has not arrived -2 kits will be needed in school

STEP 2: EMERGENCY CALLS

CALL 911/ TRANSPORT PATIENT TO THE ER

ALERT EMERGENCY CONTACTS

Mother: Home:

Work:

Cell:

Father: Home

Work:

Cell:

Other: Name:

Relationship:

Phone #:

DATE

PHYSICIAN'S SIGNATURE

EPI PEN and EPIPEN JR Order

I / We hereby request that the Meyersdale Area School District, through its appropriate personnel, administer a physician's prescribed medication to our child, as described below. I / We further hereby release and hold harmless, the Meyersdale Area School District and its employees, from any liability for injury or damages as a result of such administration of medicine.

*** The ambulance will be called after administration of an EPI PEN.**

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Parent/Guardian: Initial here if you want your child to carry his/her Epi Pen on their person _____

Consistent with the above request by the parents of the below identified child, I hereby request that the Meyersdale Area School District allow its appropriate personnel to administer a medication which I have prescribed, as follows:

DR. – Please be specific on the order for the Epi Pen – If you want Benadryl administered first and then re-assessment of patient please list that as medication number 1 and then follow with EPI as medication #2. Please note specific S&S that require admin of EPI for this child. If the allergy is severe and you want both administered together please note that as well. Please be specific on your orders. Thank you so much.

Child's name: _____

Name of Medication: 1. _____

Dosage: _____

Time to be Administered: _____

Purpose of Medication: _____

Possible Side Effects or Contraindications: _____

Name of medication: 2. _____

Dosage: _____

Time to be Administered: _____

Purpose of Medication: _____

Possible Side Effects or Contraindications: _____

Termination date for Administering the Medication: _____

Diagnosis: _____

Other medication prescribed by the physician that the student is taking outside of school hours: _____

Curtailment of specific school activity: _____
(sports, shop, lab, gym, Etc)

DATE

PHYSICIAN'S SIGNATURE

Initial here as well if you feel this patient should carry their Epi Pen with them during school hours. _____