

**OLMSTED COUNTY PUBLIC HEALTH
SCHOOL HEALTH SERVICES
ROCHESTER, MN 55904**

Place Child's Picture Here

EPIPEN EMERGENCY HEALTH CARE PLAN AND MEDICATION AUTHORIZATION

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

Emergency Contacts: (Place a 1 by the first call, a 2 by the second call, etc.)

___ Mother: _____	H: _____	W: _____	Cell/Pager: _____
___ Father: _____	H: _____	W: _____	Cell/Pager: _____
___ Other: _____	H: _____	W: _____	Cell/Pager: _____

Health Care Provider: _____ Phone: _____ Fax: _____

Preferred Hospital in Case of Emergency: _____

Medical Diagnosis: _____

Allergies: _____

Asthmatic: Yes* No **High risk for severe reaction*

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems: Symptoms: (Highlight and circle symptoms most common to this student)

- MOUTH** itching & swelling of the lips, tongue, or mouth
- THROAT*** itching and/or a sense of tightness in throat, hoarseness, and hacking cough
- SKIN** hives, itchy rash, and/or swelling about the face or extremities
- GUT** nausea, abdominal cramps, vomiting, and/or diarrhea
- LUNG*** shortness of breath, repetitive coughing, and/or wheezing
- HEART*** "thready" pulse, "passing-out"

**The severity of symptoms can quickly change.
*All above symptoms can potentially progress to a life-threatening situation!**

ACTION

1. Notify the office **IMMEDIATELY** and staff will bring the EpiPen.
2. The **"EPIPEN"** must be administered **IMMEDIATELY**.
3. A call must be placed to 911.
 - Request an Ambulance
 - Specify that a child is having an **Anaphylactic Reaction**
4. Contact parents.

PHYSICIAN'S ORDER FOR EPIPEN

MEDICATION	DOSAGE	TIME	DURATION	SELF-CARRY /ADMINISTER
1. _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

Other medications the student is taking _____

Other recommendations/unusual side effects _____

When ordering this medication self-carry/administer, I understand the student, my patient, will carry this medication at school. I also understand this student, my patient, will be entirely responsible for the use of this medication and use of this medication will not be monitored by school personnel.

Physician's signature _____ Date _____

STAFF ADMINISTRATION OF MEDICATION

PARENT/GUARDIAN AUTHORIZATION

I/we give permission for the School Public Health Nurse to consult with this student's physician concerning any questions that arise with regard to the listed medication, medical condition, or side effects of this medication.

I/we understand that trained school personnel (classroom teacher, paraprofessionals, health office staff, office staff) will follow the EpiPen Emergency Health Plan as completed by the School Public Health Nurse and myself, during scheduled school hours.

The school intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.

Parent(s)/Guardian(s) Signature

Date

Check If Not Applicable

SELF-ADMINISTRATION OF MEDICATION

PARENT/GUARDIAN AUTHORIZATION

I/we hereby authorize my student to self-administer the above named medication during scheduled school hours as prescribed by the physician. I/we have read the student agreement.

I/we understand my/our student will carry this medication at school and use will **not** be monitored by school personnel.

I/we understand that trained school personnel (classroom teacher, paraprofessionals, health office staff, office staff) will follow the EpiPen Emergency Health Plan as completed by the School Public Health Nurse and myself, should my student be unable to self-administer his/her medication.

Parent(s)/Guardian(s) Signature

Date

STUDENT AGREEMENT

I agree to:

- Follow my prescribing health professional's medication orders.
- Use correct medication administration technique.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me in school and on field trips.
- Notify the School Public Health Nurse or health office personnel if my EpiPen is administered and 911 will be called.
- Notify the School Public Health Nurse or health office personnel if I have any exposure to allergy-causing food or substances or exhibit any symptoms of an allergic reaction.

Student Signature

Date

TO BE COMPLETED BY THE SCHOOL PUBLIC HEALTH NURSE

The student has demonstrated knowledge about proper use of his/her Epi-Pen.

School Public Health Nurse

Date

Reviewed by:

School Public Health Nurse

Date