

**Howard County Public Schools
EpiPen Order Form/Care Plan**

13 30 375

Medication Form for Students with Allergic Reactions - To be completed by physician/authorized prescriber

Name: _____ Gender: M F School/Grade: _____ DOB: _____

Student Allergies: _____

Known Triggers: Ingestion Touch Sting Other (list) _____

Date of Order: _____ Order Expires End of School Year **OR** (list date): _____

Order Valid for Current Year including Summer School (check box if applies)

Physician/Prescriber Signature: _____ Phone: _____

Parent/Guardian Signature: _____ Phone: _____

EpiPen Order

EpiPen Dose: (Circle one) .15mg .30mg

Student is able to self-administer: YES NO

Student may carry EpiPen on self: YES NO

(A back-up EpiPen must be kept in Health Room)

Date EpiPen Expires: _____

Possible Side Effects: _____

Oral Medication Order

Medication: _____

Dose: _____ Strength: _____

Frequency: _____

Date Medication Expires: _____

Possible Side Effects: _____

Student
Photo

Administration Choices (please check all that apply):

_____ Administer _____ (oral medication) of _____
 for known or possible ingestion/touch/sting/other (list) _____

_____ Prior to onset of symptoms

_____ If student develops hives, rash, itchy mouth or other symptom(s) (list) _____

_____ After EpiPen is given

_____ Give EpiPen for known or possible ingestion/touch/sting/other _____ of _____

_____ Prior to onset of symptoms

_____ At first sign of any symptoms (see back for list)

_____ Only if student develops throat/lung/heart symptoms or if two or more body systems are involved (see back for list)

Other Instructions: _____

Student Name: _____

Date: _____

Anaphylaxis Symptoms (by body systems)

Mouth/Nose
 • Itching &/or swelling of lips, mouth or tongue
 • Nasal congestion
 • Runny, sniffing nose
 • Sneezing

Throat
 • Itching/tightness in throat
 • Sore throat; throat clearing
 • Hacking cough
 • Hoarseness

Gastrointestinal
 • Nausea
 • Vomiting
 • Abdominal cramps
 • Diarrhea

** Call **911** as soon as symptoms of anaphylaxis are observed and the need to administer the EpiPen has been determined
 ** Call parent after administering EpiPen and contacting EMS services.

Skin
 • Hives/wheals covering large areas of the body
 • Itchy, red skin/rash
 • Perception of feeling itchy all over
 • Flushing, itching, burning
 • Swelling, especially on face/chest

Lungs
 • Difficulty breathing
 • Chest tightness/pain
 • Cough
 • Wheezing
 • Shortness of breath

Heart (cardiac)
 • Dizziness, fainting
 • Shock (drop in blood pressure, thready pulse)
 • Palpitations
 • Unconsciousness

INSTRUCTIONS TO GIVE EPIPEN:
 1. Identify student.
 2. Remove gray safety cap.
 3. Place black tip against outer thigh.
 4. Push firmly until you hear injector function (click). Hold in place 10 seconds.
 5. Monitor student - Initiate CPR if necessary.
 6. Begin CPR if necessary.

Oral Medication Administration

(Medication)	_____ (Dose)	administered on _____ (Date)	at _____ (Time)	for _____ (Time)	Symptoms/Reasons _____	Signature _____
(Medication)	_____ (Dose)	administered on _____ (Date)	at _____ (Time)	for _____ (Time)	Symptoms/Reasons _____	Signature _____
(Medication)	_____ (Dose)	administered on _____ (Date)	at _____ (Time)	for _____ (Time)	Symptoms/Reasons _____	Signature _____

EpiPen **.15mg** or **.30mg** (circle one) was administered on _____ (date) at _____ (time) in **R** **L** (circle one) thigh.
 by _____ Signature _____ Title _____
 _____ Medication _____ Dose _____ was administered on _____ (Date) at _____ (Time) by _____ Signature/Title _____