

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

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

_____ 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

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

Other Instructions: _____

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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

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

_____ was administered on _____ at _____ by _____

Medication _____ Dose _____ Date _____ Time _____ Signature/Title _____

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