Tri-County North Schools

EMERGENCY ALLERGY PLAN/EPINEPHRINE AUTHORIZATION

(In accordance with ORC 3313.718/3313.14)

Place Student Picture Here

Parent Section

Student Name:_____ Birth Date:_____

School:_____ Grade/ Teacher: _____

Address:_____ Phone: _____
Home

As the Parent / Guardian of this student: ***I authorize*** ***Do not authorize*** *(circle one) my child to possess and self administer an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered.* ***I will provide a backup dose of the medication to the school principal or nurse as required by law****. If self administration is not authorized, the administration of this prescribed medication may be administered by trained school staff. I have read and understand Tri-County North Schools Medication Policy.* ***I give permission for this information to be sent to the school district via facsimile.***

Emergency contacts: name/relationship Phone number (s)

1._____ 1._____ 2. _____

2._____ 1._____ 2. _____

3._____ 1._____ 2. _____

Parent/Guardian name:_____ Date:_____

Parent/Guardian signature:_____ Phone _____
Work/cell

TREATMENT PLAN

To be completed by physician

Allergic To:_____ Asthmatic_____ Yes ____ No

Symptoms:		**Give circled Medication:**	
If exposed to allergen but no symptoms		Epi-Pen	Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue mouth	Epi-Pen	Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	Epi-Pen	Antihistamine
Gastro	Nausea, abdominal cramps, vomiting, diarrhea	Epi-Pen	Antihistamine
Throat	Tightening of the throat, hoarseness, hacking cough	Epi-Pen	Antihistamine
Lung	Shortness of breath, repetitive coughing, wheezing	Epi-Pen	Antihistamine
Heart	Thready pulse, low blood pressure, fainting, pale, blueness	Epi-Pen	Antihistamine
Other _____		Epi-Pen	Antihistamine

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MEDICATION ORDERS

To be completed by physician

Student Name_____ Birth Date _____

Antihistamine:_____
Name of medication

Dose:_____ **Time to be given:** _____

Date administration is to: Begin:_____ End: _____

Adverse reactions that should be reported to the physician:

For the student for which it is prescribed:_____

_____

For the student for which it is ***not*** prescribed who receives a dose: _____

_____

Epinehphrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr.

Date administration is to: Begin:_____ End: _____

Circumstances for the use of the autoinjector_____

_____

Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief: _____

_____

Adverse reactions that should be reported to the physician:

To the student for which it is prescribed:_____

_____

To a student for which it is ***not*** prescribed who receives a dose :_____

_____

Special instructions: _____

EMERGENCY MEDICAL SERVICE PROVIDER (911) WILL BE CALLED IF EPINEPHRINE IS ADMINISTERED

_____As the prescriber, I have determined that this student ***is capable*** of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

_____As the prescriber, I have determined that this student ***is not*** capable of possessing and using this autoinjector appropriately and administration of this medication may be supervised by medically untrained personnel, it is requested that the medication be given by school personnel.

Physician Name:_____ Phone Number _____

Fax number _____ Emergency phone number:_____

Physician Signature_____ Date_____