Prince George's County Public Schools

DEPARTMENT OF HEALTH SERVICES

Parent's/Guardian's and Physician's Medication Authorization For Emergency Medication – EPIPEN – For Management of Acute Allergic Reaction

THIS IS A LIFE THREATENING EVENT

FOR COMPLETION BY PARENT(S)/GUARDIAN(S)

Full Name of Student: ________________________ Birthday____/____/____ School Year:____________

Name of School:____ Grade:______________

- I understand that I must supply the school with the necessary equipment/supplies.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- **911 will be called immediately.**

1. Is your child capable of self-administering the Epipen, if needed? ❐ Yes ❐ No
2. Do you want instructions in Epipen administration to be reviewed with your child? ❐ Yes ❐ No
3. Does your child need to carry the Epipen with him or her during the school day? ❐ Yes ❐ No

______________________________ ______________

Signature of Parent/Guardian Date

FOR COMPLETION BY PHYSICIAN

ANAKIT AND TWINJECT WILL NOT BE ACCEPTED

1. Name of medication: **EPIPEN (EPINEPHRINE AUTO INJECTOR)**

   School personnel will be taught by a registered nurse to administer the epipen. These individuals are non-medical school staff. Medical orders must be clear and explicit as to when the epipen is to be given. These personnel will not make medical judgments or observe for medical symptoms.

2A. Reason for medication: Management of acute allergic reactions :
Check one: _____ Stinging allergy
_____ Ingestion of ________________________
(specify)

2B. Medication allergy:
____
Medication Name

3. Medication is to be given: *(Check one)*
_____ a. **Immediately** after insect sting or _____ b. **Immediately** after ingestion of ________________
(specify)

4. Route of administration: **Autoinjection into anterolateral aspect of the thigh**
5. Dosage of medication: *(Check one)* ____ Epipen 0.15 mg. ____ Epipen 0.3 mg.
6. Side effects ____
7. **911 WILL BE CALLED IMMEDIATELY.**

______________________________ ______________________________

Physician's Signature
(Original signature/NO stamps)
Date

______________________________ ______________________________

Physician's Printed Name
Physician's Address

______________________________ ______________________________

Physician's Telephone Number
Physician's Address

This medication authorization is only valid for the current school year.

Reviewed by Health Services R.N.________________________________ Date ____________