Oakwood School District #76

Request for: Epinephrine Auto-Injector and/or Benadryl

Student will self-carry and self-administer unless the box below is checked:

❑ **Do not allow student to self-carry or self-administer medication**

Part 1: To be completed by a Physician licensed to practice medicine in all branches, Physician Assistant or Advanced Practice Registered Nurse

Student Name: _____ Birthdate: _____

Name of Medication: _____

Dosage: _____

Route of Administration: _____

Frequency & Time of Administration: _____

Diagnosis: _____

Other medications student is receiving: _____

Possible Side Effects: _____

Start Date: _____ Stop Date: _____

I, _____, have in-serviced the above named student regarding the prescribed epinephrine auto-injector and its proper use. I am requesting that he/she be allowed to carry the epinephrine auto-injector on his/her person and assume full responsibility for its use during school hours and extracurricular activities.

Licensed Prescriber(print): _____ Signature:_____

Address: _____

_____

Telephone:_____

Date:_____

***Health Care Provider: Please complete the Allergy Action Plan on the back of this sheet**

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Part 2: To be completed by the parent or legal guardian

I _____, request and give permission for my son/daughter to carry the prescribed epinephrine auto-injector on his/her person. I accept full responsibility for my child's ability to properly use the epinephrine auto-injector. I hereby release Oakwood School Dist. 76 and its employees from any responsibility to the use/misuse of the epinephrine auto-injector by my son/daughter. I will obtain a new doctor's order if there is a change in the prescribed epinephrine auto-injector. Lastly, I hereby give permission for the school nurse to discuss the details of this order with the Licensed Prescriber.

Parent/Guardian Signature:_____ Date: _____

Address:_____ Phone Number:_____

Oakwood School District 76
Allergy Action Plan

Student Name:_____ **Date of Birth:**_____

Allergic to: _____

Weight: _____ Asthma: YES(High risk for severe reaction) / NO

EXTREMELY REACTIVE TO THE FOLLOWING ALLERGENS:_____

- ❑ **If checked, give Epinephrine immediately if the extreme allergen was LIKELY eaten, for any symptom**
- ❑ **If checked, give Epinephrine immediately if the extreme allergen was DEFINITELY eaten, even if no symptoms are apparent.**

Do not depend on Inhalers or antihistamines to treat severe reactions. USE EPINEPHRINE

For any of the following SEVERE SYMPTOMS						
Lung	**Heart**	**Throat**	**Mouth**	**Skin**	**Gut**	**Other**
-Shortness of breath -Wheezing -Repetitive cough	-Pale/blue skin -Faintness -Weak pulse -Dizziness	-Tight / Hoarse -Trouble breathing or swallowing	-Swelling of lips or tongue	-Many hives over body -Widespread redness	-Repetitive vomiting -Severe diarrhea	-Impending doom -Anxiety -Confusion
****<u>INJECT EPINEPHRINE IMMEDIATELY!!!</u>****						

MILD SYMPTOMS			
Nose	**Mouth**	**Skin**	**Gut**
-Itchy/ runny nose -Sneezing	-Itchy mouth	-Few Hives -Mild itch	-Mild nausea or discomfort
For mild symptoms from **1 system**, follow directions below:			
1. Antihistamines may be given if ordered(benadryl) 2. Stay with person and alert emergency contacts 3. Watch closely for changes. If symptoms worsen give epinephrine 4. If multiple symptoms from more than one system area are present, prepare to give epinephrine if any severe symptoms develop.			

Medications and doses			
Treatments	**Medication Name**	**Dose**	**Directions**
Epinephrine			
Antihistamine			
Bronchodilators			

Physician Signature:_____ Date: _____

Parent Signature:_____ Date:_____

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