



**PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR  
ADMINISTRATION OF MEDICATION IN SCHOOL**

**A. To be completed by the parent or guardian:**

I request that my child \_\_\_\_\_ DOB \_\_\_\_\_  
receive the medication as prescribed below by our physician. The medication is to be  
furnished by me in the properly labeled original container from the pharmacy.\*

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**B. To be completed by the Private Healthcare Provider:**

I request that my patient, as listed below, receive the following medication:

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_ Frequency \_\_\_\_\_

Time to be taken during school hours \_\_\_\_\_

Possible side effects or adverse reactions (if any):

\_\_\_\_\_

Health Care Provider's  
signature: \_\_\_\_\_ Date \_\_\_\_\_

Physician Information: (Please Stamp)

This medication order is valid for SCHOOL YEAR 2023-2024

\*Medication must be in the original pharmacy labeled container with specific orders and name of student  
and medication.

\*\*Medication and refills must be brought to school by a parent, guardian or responsible adult.



PLACE  
PICTURE  
HERE

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs. Asthma:  Yes (higher risk for a severe reaction)  No

**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

**Extremely reactive to the following allergens:** \_\_\_\_\_

**THEREFORE:**

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:  
**SEVERE SYMPTOMS**



**LUNG**

Short of breath,  
wheezing,  
repetitive cough



**HEART**

Pale, blue,  
faint, weak  
pulse, dizzy



**THROAT**

Tight, hoarse,  
trouble  
breathing/  
swallowing



**MOUTH**

Significant  
swelling of the  
tongue and/or lips



**SKIN**

Many hives over  
body, widespread  
redness



**GUT**

Repetitive  
vomiting, severe  
diarrhea



**OTHER**

Feeling  
something bad is  
about to happen,  
anxiety, confusion

**OR A  
COMBINATION**  
of symptoms  
from different  
body areas.



- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
  - Consider giving additional medications following epinephrine:
    - » Antihistamine
    - » Inhaler (bronchodilator) if wheezing
  - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
  - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
  - Alert emergency contacts.
  - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

## MILD SYMPTOMS



**NOSE**

Itchy/runny  
nose,  
sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives,  
mild itch



**GUT**

Mild nausea/  
discomfort

**FOR MILD SYMPTOMS FROM MORE THAN ONE  
SYSTEM AREA, GIVE EPINEPHRINE.**

**FOR MILD SYMPTOMS FROM A SINGLE SYSTEM  
AREA, FOLLOW THE DIRECTIONS BELOW:**

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

## MEDICATIONS/DOSES

Epinephrine Brand or Generic: \_\_\_\_\_

Epinephrine Dose:  0.15 mg IM  0.3 mg IM

Antihistamine Brand or Generic: \_\_\_\_\_

Antihistamine Dose: \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if wheezing): \_\_\_\_\_

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

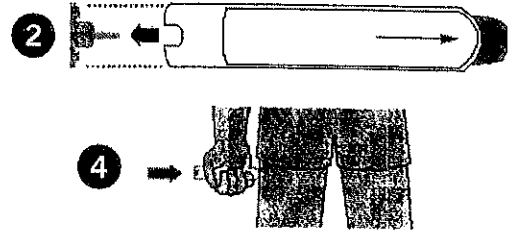
PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



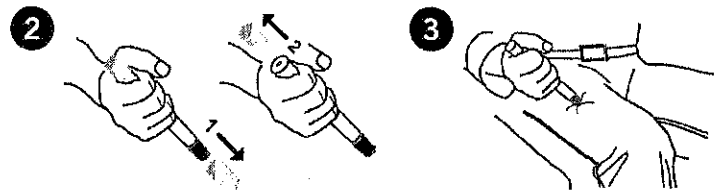
**EPIPEN® AUTO-INJECTOR DIRECTIONS**

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



**ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS**

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.



**ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:**

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

**OTHER DIRECTIONS/INFORMATION** (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

**EMERGENCY CONTACTS — CALL 911**

RESCUE SQUAD: \_\_\_\_\_  
DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_  
PARENT/GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

**OTHER EMERGENCY CONTACTS**

NAME/RELATIONSHIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
NAME/RELATIONSHIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_