St Louis School
EpiPen Order Form/Care Plan
Medication Form for Students with Allergic Reactions– To be completed by physician/authorized prescriber

Name: _____ Gender: M F 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 applicable)

Physician/Prescriber Signature: _____ Phone: _____

I hereby request and authorize St. Louis School personnel to administer prescribed EpiPen and Benadryl as directed by the physician/authorized prescriber above. I agree to release, indemnify and hold harmless St. Louis School and any of their faculty, staff, agents or related entities from lawsuit, claim, or action against them for administering the above medication to this student, provided St. Louis School faculty, staff or agents are attempting to follow the physician's order as written below. I understand that the EpiPen/Benadryl may be administered by faculty, staff or agents who are not trained medical providers. I also understand that, with the exception of the school nurses, St. Louis School's faculty, staff or agents are not trained to recognize the signs and symptoms of an allergic reaction. I further agree to release, indemnify and hold harmless St. Louis School and any of their faculty, staff, agents or related entities from any lawsuit, claim, demand or action against them arising from the student's self-administration of the EpiPen/Benadryl.

I hereby authorize St. Louis School to release the information in this document or a copy of the document to all St. Louis personnel or agents.

911 will be called whenever an EpiPen is administered.

Parent/ Guardian Signature: _____ Phone: _____

EpiPen Order

EpiPen Dose: (Circle one) 0.15 mg 0.3 mg

Student is able to self-administer: YES NO

Student may carry EpiPen on self: YES NO

(A backup EpiPen must be kept in the 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 (see back for list)

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

Other Instructions: _____

Student Name: _____ Date: _____

Anaphylaxis Symptoms (by body systems)

Mouth/Nose

- Itching and/or swelling of lips, mouth or tongue
- Nasal congestion
- Runny, sniffling 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, thread 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)
5. Hold in place 10 seconds
6. Monitor student—Initiate CPR if necessary
7. 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 .15 mg .30 mg (circle one) was administered on _____ (date) at _____ (time) for _____ in R L (circle one) thigh.

Auvi-Q .15 mg .30 mg (circle one) was administered on _____ (date) at _____ (time) for _____ in R L (circle one) thigh.

By _____ _____

Signature Title

_____ _____ was administered on _____ at _____ by _____

(Medication) (Dose) (Date) (Time) (Signature/Title)