

SANBORN REGIONAL SCHOOL DISTRICT

SRSD File: JLCE-R1

EPI-PEN ADMINISTRATION FORM FOR STUDENTS WITH SEVERE ALLERGIES

Prescriber completes side 1

Parent/Guardian completes side 2

Student Name _____ Date of Birth _____

Allergen _____

Current Medication List: (Please list all medications student is currently taking.)

Medication: _____ Dose _____ Route _____ Time/Frequency _____

Medication: _____ Dose _____ Route _____ Time/Frequency _____

Medication: _____ Dose _____ Route _____ Time/Frequency _____

Treatment Plan for Exposure

Immediate Treatment (i.e., Benedryl vs. Epi-Pen) _____

Action for increase in severity of symptoms: _____

Medication: _____

Dose: _____ Route _____ Time/Frequency _____

Medication: _____

Dose: _____ Route _____ Time/Frequency _____

Student Self Administration for Epi-Pen (If Applicable)

I have instructed (student name): _____ in the correct way to use and administer (medication name): _____ It is my professional opinion that he/she has the knowledge and skills to safely carry and administer this medication by in school.

_____ Yes _____ No

Prescriber's name (print): _____ Office Phone: _____

Prescriber's signature: _____ Date: _____

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Prescriber completes **side 1**

Parent/Guardian completes **side 2**

Student Name _____ DOB _____ Grade _____

Parent/Guardian _____ Home # _____ Cell # _____

Work# _____ Prescriber's Name _____ Office Phone # _____

Allergen: _____ Does child have Asthma? ___ Yes ___ No

The date of child's last reaction & treatment _____

System	Symptoms (Please circle all symptoms your child has experienced with exposure)
Mouth	Itching + swelling of the lips, tongue, or mouth
Throat	Itching +/- or sense of tightness in the throat; hoarseness; hacking cough
Skin	Hives; itchy rash +/- or swelling around the face, arms, or legs
Gut	Nausea, abdominal cramps, vomiting, diarrhea
Lung	Shortness of breath; repetitive coughing; wheezing
Heart	"Thready" pulse; passing out

This information will be shared with your child's teachers and school staff as appropriate.

It is a Parent/Guardian's responsibility to share your child's medical conditions and treatment with transportation personnel (bus drivers).

Hold Harmless Statement:

I, the parent/guardian of (Student name _____), authorize the school administrator to direct members of the school staff to assist my child in taking the above Medication and agree that I will not hold liable, any member of the school staff or individual of official capacity who is directed by me (parent/guardian) and the school administrator to assist my child in taking said medication.

Authorization for release of information:

I give my permission for the release/exchange of pertinent information between the school nurse and the licensed prescriber's office regarding all of the medical/medication information described on this form concerning my child.

Self Administration: (If Applicable)

My child has been instructed in the correct way to use _____ Epi-Pen **or** _____ Epi-Pen, Jr. and should be permitted to carry and use that medication by himself/herself without supervision.

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ Date: _____

Reaffirmed 5/15/19

Side 2