NELSON COUNTY SCHOOLS

Authorization to Give Medication - Epipen

Medications will be given at school only with written permission from the child's parent(s) or legal guardian. Emergency medications must have the written permission from the physician administer. Signed permission will expire at the end of the school year.

Student's Name _____ **Date of Birth** _____

IF EXPOSURE TO ALLERGEN OCCURS, ACTIVATE THE FOLLOWING EMERGENCY PLAN OF ACTION.

EMERGENCY PLAN OF ACTION

1. Administer emergency medication*
   Allergen: (list what child is allergic to) _____
   Medication _____
   Dosage _____
   Route _____
2. Call EMS (911) if:
3. Notify school personnel trained in CPR/First aid to stay with student and initiate CPR if needed prior to EMS arrival.
4. Notify parent/guardian.
5. If child needs to be transported via EMS, a parent or school representative will meet student at the hospital.

DO NOT HESITATE TO ADMINISTER MEDICATION AND CALL EMS FOR ASSISTANCE!!!!

If exposure to known allergen is uncertain, continuously observe student for signs and symptoms of an allergic reason such as:

Systems	Symptoms
Mouth	Itching and swelling of the lips, tongue, or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Stomach	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	Low and weak heart rate, "passing out"

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

EpiPen should be: ☐ kept with the child ☐ kept in the front office ☐ available during bus transportation ☐ other

_____

Signature of MD, ARNP, or PA _____ **Date** _____

Primary Care Provider _____

Address _____

Phone # _____

I give permission for myself/my child to receive the above medication at school and waive any liability on behalf of the school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication. My signature will give permission for exchange of verbal and written communication between the physician and the school nurse/health staff regarding my child's medical regime.

Signature of Parent or Legal Guardian _____ **Date** _____

Home phone _____ **Work phone** _____

Emergency contact name _____ **Phone number** _____