

STUDENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthmatic  Yes\*  No  
\*Higher risk for severe reaction

◆ **STEP 1: TREATMENT** ◆

To be determined by physician authorizing treatment

**Symptoms:**

- If a food allergen has been ingested, but *no symptoms*:
- Mouth = itching, tingling, or swelling of lips, tongue, mouth
- Skin = Hives, itchy rash, swelling of the face or extremities
- Gut = Nausea, abdominal cramps, vomiting, diarrhea
- Throat † Tightening of throat, hoarseness, hacking cough
- Lung † Shortness of breath, repetitive coughing, wheezing
- Heart † Thready pulse, low blood pressure, fainting, pale, blueness
- Other † \_\_\_\_\_
- If reaction is progressing (several of the above areas affected), give

**Give Checked Medication:**

- EpiPen  Antihistamine
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The severity of symptoms can quickly change. † Potentially life-threatening.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

◆ **STEP 2: EMERGENCY CALLS** ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_) . State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

**3. Parent & Emergency Contacts**

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)

**TRAINED STAFF MEMBERS**

- 1. \_\_\_\_\_ Room \_\_\_\_\_
- 2. \_\_\_\_\_ Room \_\_\_\_\_
- 3. \_\_\_\_\_ Room \_\_\_\_\_

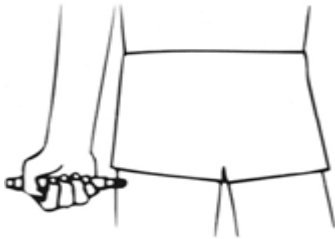
**EpiPen® and EpiPen® Jr. Auto Injector**

**Directions:**

- First remove the EpiPen Auto-Injector from the plastic carrying case
- Pull off the **BLUE** safety release cap



- Hold **ORANGE** tip near outer thigh  
(Always apply to thigh).



- Swing and firmly push orange tip against outer thigh. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

**I give permission for my son/daughter to self-administer their Epinephrine as prescribed by his/her physician.**

\_\_\_\_\_ Yes    \_\_\_\_\_ No

**I give permission for the school nurse (or appropriately trained school personnel) to administer Epinephrine and share information as deemed necessary for my child's health and safety.**

\_\_\_\_\_  
**Parent/Guardian Signature                      Date**

**Epinephrine Locations:** \_\_\_\_\_

\_\_\_\_\_

**Epinephrine Expiration Date:** \_\_\_\_\_