

**OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON**

**EPIPEN AUTHORIZATION**

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

**PART I TO BE COMPLETED BY PARENT OR GUARDIAN**

I hereby request designated school personnel to administer an epinephrine injection as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for administering this injection, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of part II below. I am aware that the injection may be administered by a specifically trained non-health professional. I have read the procedures outlined on the back of this form and assume responsibility as required

I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

Student Name (Last, First, Middle) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Allergies \_\_\_\_\_ School \_\_\_\_\_ School Year \_\_\_\_\_

No LPN or clinic room aide shall administer inhaler or treatment, unless the principal has reviewed all the required clearances

\_\_\_\_\_  
Parent or Guardian Signature Daytime Telephone Date

**PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS.**

Emergency injections may be administered by non-health professionals. These persons are trained by qualified registered nurses to administer the injection. For this reason, only pre-measured doses of epinephrine (EpiPen auto injector) may be given. It should be noted that these staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.

The following injection will be given immediately after report of exposure to \_\_\_\_\_  
(Indicate specific allergens)

Route of Exposure:  Ingestion  Skin contact  Inhalation  Insect bite or sting

Check  appropriate boxes:

- EpiPen
  - Give the pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution (0.3cc) by auto injection intramuscularly in anterolateral thigh.
  - Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)
- EpiPen Jr.
  - Give the pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution (0.3 cc) by auto injection, intramuscularly in anterolateral thigh.
  - Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)

**COMMON SIDE EFFECTS**

EFFECTIVE DATE: Start: \_\_\_\_\_ End: \_\_\_\_\_ If the student is taking more than one medication at school, list sequence in which medications are to be taken

Check  appropriate box:

- I believe that this student has received adequate information on how and when to use an EpiPen, and has demonstrated its proper use.
  - a. The student is to carry an EpiPen during school hours with principal approval. The student can use the EpiPen properly in an emergency.
  - b. One additional dose, to be used as backup, should be kept in clinic or other school location.
- The EpiPen will be kept in the school clinic or other school approved location \_\_\_\_\_  
Allergy Action Plan is attached.

Licensed Health Care Provider (Print or Type) \_\_\_\_\_ Licensed Health Care Provider (Signature) \_\_\_\_\_ Telephone or Fax \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian (Print or Type) \_\_\_\_\_ Parent or Guardian Signature \_\_\_\_\_ Telephone \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Student Signature (Required if student carries EpiPen) Date

**PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE**

Check  as appropriate:

- Parts I and II above are completed including signatures. (It is acceptable if all items in part II are written on the LHCP stationery or a prescription pad.)
- EpiPen is appropriately labeled. \_\_\_\_\_ Date by which any unused EpiPens are to be collected by the parent (within one week after expiration of the physician order or on the last day of school).
- I have reviewed the proper use of an EpiPen with the student and agree/disagree that student should self carry in school.

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

## PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual.**
2. **Schools do NOT provide medications for student use.**
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over The Counter (OTC) medication administered in school.
5. **All medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days also require a licensed healthcare provider's (LHCP) written order. No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.**
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
  - a. Student name
  - b. Date of Birth
  - c. Diagnosis
  - d. Signs or symptoms
  - e. Name of medication to be given in school
  - f. Exact dosage to be taken in school
  - g. Route of medication
  - h. Time and frequency to give medications, as well as exact time interval for additional dosages.
  - i. Sequence in which two or more medications are to be administered
  - j. Common side effects
  - k. Duration of medication order or effective start and end dates
  - l. LHCP's name, signature and telephone number
  - m. Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and it's expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
  - a. Name of student
  - b. Exact dosage to be taken in school
  - c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON  
ALLERGY ACTION PLAN

PROCEDURE ON REVERSE

**PART I TO BE COMPLETED BY PARENT**

Student \_\_\_\_\_ D.O.B \_\_\_\_\_ School \_\_\_\_\_

ALLERGY \_\_\_\_\_ Teacher/Grade \_\_\_\_\_

**Emergency Contacts:**

Name/Relationship

Phone Number(s)

\_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

\_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

Asthmatic

Yes\*

No

\*Higher risk for severe reaction

**PART II TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER**

**TREATMENT PLAN FOR ABOVE ALLERGY**

For medications administered during school sanctioned activities, complete required EpiPen/Medication Authorization forms.

**Symptoms:**

**Give Checked Medication:**

- |  |                                      |  |
|--|--------------------------------------|--|
| • If a food allergen has been ingested, but <i>no symptoms</i> :         | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Mouth Itching, tingling, or swelling of lips, tongue, mouth            | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Skin Hives, itchy rash, swelling of the face or extremities            | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Gut Nausea, abdominal cramps, vomiting, diarrhea                       | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Throat* Tightening of throat, hoarseness, hacking cough                | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Lung* Shortness of breath, repetitive coughing, wheezing               | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Heart* Thready pulse, low blood pressure, fainting, pale, blueness     | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Other* _____   | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • If reaction is progressing (several of the above areas affected), give | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

\*Potentially life-threatening. The severity of symptoms can quickly change.

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one)

EpiPen®

EpiPen® Jr.

**Antihistamine:** give \_\_\_\_\_

medication/dose/route

**Other:** give \_\_\_\_\_

medication/dose/route

**PLACE EMERGENCY CALLS**

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

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

\_\_\_\_\_  
Licensed Health Care Provider (Print)

\_\_\_\_\_  
Licensed Health Care Provider (Signature)

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

I approve of this Allergy Action Plan, I give permission for school personnel to perform and carry out the tasks as outlined. I consent to the release of the information contained in this management plan to all staff members and others who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

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

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

Adapted from: Virginia Department of Health, Virginia Department of Education. (2004) *Guidelines for Specialized Health Care Procedures*

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**ALLERGY ACTION PLAN**  
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**PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE**

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher/Grade \_\_\_\_\_

Parent/Caregiver \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

ALLERGY \_\_\_\_\_

**ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL**

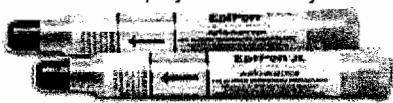
- Allergy Action Plan Part I and II, complete yes      no
- Medication authorization complete yes      no      n/a
- EpiPen authorization complete yes      no      n/a
- Medication maintained in school designated area yes      no
- Medication self carried yes      no
- Expiration date of medication(s) \_\_\_\_\_
  
- Staff trained in medication administration yes      no
- Copies of plan provided to:
 

Educational	yes	no	n/a	After school	yes	no	n/a
Athletic	yes	no	n/a.	Food service	yes	no	n/a

**Trained staff**

Name _____	Date _____	Location _____
Name _____	Date _____	Location _____
Name _____	Date _____	Location _____
Name _____	Date _____	Location _____

The EpiPen is self-injecting. It is used in cases of anaphylaxis of any cause.



Directions for use:

- Remove gray safety cap and grasp EpiPen with your fist
- Press the black end of EpiPen against outer thigh until you hear a click and needle is released. EpiPen is designed to be used through clothing if necessary.
- **Maintain EpiPen in position for 10 seconds**
- Remove EpiPen, call 911 for immediate follow up and send the pen with the caregiver to the emergency room.
- Use care with exposed needle. Destroy needle by placing a penny into empty tube and inserting spent pen. New packaging allows inserting the pen without a penny.

**Full Allergy Action plan has been implemented.**

Principal or Registered Nurse \_\_\_\_\_ Date \_\_\_\_\_