PLAINVILLE COMMUNITY SCHOOLS

Plainville, CT 06062

Authorization for EpiPen/Benadryl Administration by School Personnel or Self-Administration

Connecticut State Law requires a written order from an authorized prescriber (*MD, DDS, OD, DO, PA, APRN*) and parent/guardian/eligible student (18 years old or emancipated minor) authorization for both prescription and non-prescription medications. All medications shall be delivered to the school by the parent, guardian, eligible student or other responsible adult. The medication must be stored in the original labeled container as dispensed from the pharmacy.

Name of Student: ____ DOB: ______________________ Grade: ________

Known Allergies: ____

If student ingests or thinks he/she has ingested the above named food or has been stung by above named insect***:*** _______________

____

Please **note** desired order(s): | **Circle desired epinephrine injector dosage:**

____________ Observe patient for symptoms of anaphylaxis***

____________ Administer Benadryl ______ tsp. Swish and swallow

____________ Administer epinephrine ***before*** symptoms occur - **EpiPen/_____________ 0.15 mg. 0.3 mg**

____________ Administer epinephrine ***if*** symptoms occur - **EpiPen/ _____________ 0.15 mg. 0.3 mg**

____________ Administer ____

9-1-1 will be called for anyone with anaphylactic symptoms or EpiPen administration.

***Symptoms of Anaphylaxis may include: Chest tightness, cough, shortness of breath, wheezing, tightness in throat, difficulty swallowing, hoarseness, swelling of lips, tongue or throat, itching mouth or skin, hives or swelling, stomach cramps, vomiting or diarrhea, dizziness or fainting.

Side Effects and Management: ____

Special Instructions: ____

Student is capable of self-administration of EpiPen: ☐ Yes ☐ No (If Yes, prescriber training is required.)

Student has been trained in self-administration of this medication in prescriber's office: ☐ Yes ☐ No

Dates of Administration: From: __________ To: ______________

Signature: **____(Physician / Authorized Prescriber) Date: _____________**

Address: ____ Phone: ______________________________

Authorization of Parent / Legal Guardian / Eligible Student

I hereby give permission for qualified personnel to administer / my child to self-administer / the medication above as ordered by his or her authorized prescriber. I understand that if my child is authorized for self-administration any misuse of this medication will result in disciplinary consequences following Board of Education policy and procedure. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.
I give permission for release and exchange of information on this form between the school nurse and authorized prescriber for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/ Legal Guardian/Eligible Student: ____
Date: _______________ Phone: _________________________________ Emergency Number: _______________________________

I give permission for release and exchange of information on this form between the school nurse and authorized prescriber for

confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian/Eligible Student:____________________________________

Date:______________________________ Phone: ____________________________

School Nurse Authorization

Self-administration of medication may be authorized by the prescriber and parent/legal guardian and must be approved by the school nurse in accordance with Board policy/procedure.

School Nurse Approval for Self-Administration: ☐ **Yes** ☐ **No:** ______________________________

RN Signature: ______________________________ **Date:** ______________________________