

MT. EPHRAIM PUBLIC SCHOOLS  
**AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE**  
HEALTHCARE PROVIDER'S ORDER

Student's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Grade: \_\_\_\_\_

The above named student is under my care

for: \_\_\_\_\_

History of anaphylaxis: Actual \_\_\_\_\_ Potential \_\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signs of Allergic Reaction:

\_\_\_ Mouth (Itching, swelling of oral area)

\_\_\_ Throat (Tightness, cough, hoarseness)

\_\_\_ Skin (Hives, rash, swelling of face/extremities)

\_\_\_ Lungs (Shortness of breath, cough/wheeze)

\_\_\_ GI (Nausea, vomiting, abdominal cramps/diarrhea)

\_\_\_ Heart (Rapid, thready pulse)

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

To be given

for: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

To be given

for: \_\_\_\_\_

This student has been trained and is able to self-administer the pre-filled auto injector mechanism of epinephrine. Yes \_\_\_\_\_ No \_\_\_\_\_

If the student is unable to self-administer the epinephrine, the school nurse will administer the epinephrine.

If, for any reason, the school nurse is unable to administer the epinephrine, a predetermined delegate

trained by the school nurse will administer the epinephrine. If, for any reason, the delegate is unable to

administer the epinephrine, 9-1-1 will be called to support the student. **Antihistamines cannot be given by the delegate. The delegate will administer epinephrine only and call 9-1-1.**

I understand that after the administration of epinephrine in the school setting, 9-1-1 will be called to transport the student to the nearest hospital for further evaluation and treatment.

Healthcare Provider's Name (PLEASE

PRINT): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone  
Number: \_\_\_\_\_

Healthcare Provider's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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As parent or guardian of \_\_\_\_\_, I request that the prescribed medication(s) be administered to the above named student. I release all Board Personnel and the Board of Education from any and all liability arising from the administration of, or failure to administer the medication(s), including the administration of epinephrine by the school nurse or the trained delegate who shall be permitted to administer epinephrine to my child when the school nurse is not physically present at the scene.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_