OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON

CS0/15-H2A

EPINEPHRINE AUTO INJECTION 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 (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.

Indicate the type of Epinephrine Auto Injection device prescribed: ____________________

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 indicating the dosage:

□ 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.)

□ 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 auto injector, and has demonstrated its proper use.

a. The student is to carry an auto injector during school hours with principal approval. The student can use the auto injector properly in an emergency.

b. One additional dose, to be used as backup, should be kept in clinic or other school location.

□ The auto injector 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 auto injector) ____________ 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.)

□ Auto injector is appropriately labeled. ____________ Date by which any unused auto injectors 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 auto injector 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.**
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. **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, auto injector). 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 prescribed by a doctor or dentist and must be in the original, small, sealed container with a current pharmacy prescription label. **Medication sent in baggies or unlabeled containers will not be given.**
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, auto injector)
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.

I hereby request that the medication specified above be given to the above named student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Diocese of Charleston, its servants, agents, and employees, including, but not limited to the parish, school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Diocese of Charleston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Signature of Parent/Guardian:____ Date:__________________

CSO/15-H2

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
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 *no symptoms*:		☐ Epinephrine	☐ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
• Throat*	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
• Lung*	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
• Heart*	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
• Other*	______________________________	☐ Epinephrine	☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ 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

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF CHARLESTON
ALLERGY ACTION PLAN
PAGE 2

PART III TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Student____________________ **School**____________________ **Teacher/Grade** __________

Parent/Caregiver ____________________ **Phone (H)** __________ **(W)** __________ **(C)** __________

ALLERGY ____

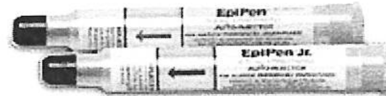
ACTION PLAN CHECK LIST FOR SCHOOL PERSONNEL

- 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

Full Allergy Action plan has been implemented.

__________________________ __________________
Principal or Registered Nurse Date