CHRIST LUTHERAN CHURCH & SCHOOL

ADMINISTRATION OF EPINEPHRINE IN SCHOOL

PARENTAL CONSENT FOR THE ADMINISTRATION OF EPINEPHRINE IN SCHOOL

STUDENT INFORMATION

FOR COMPLETION BY PARENT OR LEGAL GUARDIAN

No medication will be administered by Christ Lutheran School staff without the prior authorization of the student's Physician and the consent of the parent or legal guardian.
THIS FORM, WITH PROPER AUTHORIZATION, MUST BE ON FILE.

Student Name: _____	**DOB:** _____
Teacher: _____	Grade: _____

What is your child allergic to?	☐ Dairy	☐ Peanuts	☐ Soy	☐ Other:_____
	☐ Eggs	☐ Sesame	☐ Sting	☐ Other:_____
	☐ Fin Fish	☐ Shellfish	☐ Tree Nuts	☐ Other:_____

Signs and Symptoms of Severe Allergic Reaction
☐ Breathing difficulty: wheezing, chest tightness, difficulty swallowing
☐ Severe swelling: face, tongue, throat, or around eyes
☐ Hives: redness, sweating, itching (more alarming if on the upper chest, neck, or head)
☐ Stomach: nausea, vomiting, diarrhea, or abdominal cramps
☐ General: apprehension/panic, blue lips, pale, dizzy, convulsions
☐ Other: _____

Has your child ever been allergy tested? ☐ Yes ☐ No

If yes, date tested: _____

Name of Physician Who Administered Testing: _____

PARENTAL CONSENT:

Christ Lutheran School shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose auto injector mechanism containing Epinephrine. I shall indemnify and hold harmless Christ Lutheran School and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto injector containing epinephrine to my child in accordance with authorization provided by my child's physician and myself. I will be responsible for obtaining the prescription and the signed consent from my child's physician and for providing the school with an appropriate amount of Epinephrine Auto Injector and for replacing any expired Epinephrine Auto Injector on a timely basis. I understand that this entire consent ***must be renewed annually.***

Date: _____ Parent/guardian Signature: _____

Printed Name: _____ Relationship: _____

CHRIST LUTHERAN CHURCH & SCHOOL

ADMINISTRATION OF EPINEPHRINE IN SCHOOL

ANAPHYLAXIS TREATMENT PLAN AND PHYSICIAN'S ORDER FORM

Student Name: _____ **DOB:** _____

STUDENT ALLERGY HISTORY:

Has this student had an anaphylactic reaction? ☐ Yes ☐ No

What is this student allergic to?	☐ Dairy	☐ Peanuts	☐ Soy	☐ Other: _____
	☐ Eggs	☐ Sesame	☐ Sting	☐ Other: _____
	☐ Fin Fish	☐ Shellfish	☐ Tree Nuts	☐ Other: _____

Has the student and family been educated about the avoidance of the offending agent?
☐ Yes ☐ No

Has the student and family been educated in the indications for EpiPen/EpiPen Jr. administration, checking outdated medicine, and storing the EpiPen/EpiPen Jr.? ☐ Yes ☐ No

If insect bite, has student had venom testing? ☐ Yes ☐ No
Has student been desensitized to the venom? ☐ Yes ☐ No

Does student have a medical alert bracelet? ☐ Yes ☐ No

In your opinion, is this student able to safely self-administer the EpiPen/EpiPen Jr.? ☐ Yes ☐ No

CHRIST LUTHERAN SCHOOL EPIPEN PROTOCOL:

Christ Lutheran School has adopted the following protocol for the use of the EpiPen/EpiPen Jr. This protocol will be followed for all students who have been identified by their physician as having an allergy with the potential for an anaphylactic reaction and for who an EpiPen/EpiPen Jr. has been prescribed.

1. A student who has been previously identified by his or her physician as having an allergy with the potential for an anaphylactic reaction, and who manifest signs of anaphylaxis, will be treated with EpiPen/EpiPen Jr. Administration is IM into anterolateral thigh.
2. Student dose (check one) ☐ EpiPen Jr. **0.15mg** ☐ EpiPen **0.30mg**
3. 911 will be called and the student will be transported to the nearest emergency department.
4. A second dose of EpiPen/EpiPen Jr. may be given, if available, if EMS has not arrived or symptoms of anaphylaxis have not abated after 5 - 15 minutes.
5. Do you agree with the above treatment plan? ☐ Yes ☐ No
6. If you answered no to #5, please make modifications to this protocol regarding the indications and mode of treatment. Please specify medication(s) ordered, the order of administration, and the disposition of the patient. Please use back of page if necessary.
   Note: If prescribing Benadryl please state whether it is to be given before or after EpiPen/EpiPen Jr.

Date: _____ **Perscribers's Signature:** _____

Printed Name: _____ **Phone Number:** _____

Please return this form to: Christ Lutheran School Office, (310) 831-0848 x3 or fax (310) 831-0090

CHRIST LUTHERAN CHURCH & SCHOOL

ADMINISTRATION OF EPINEPHRINE IN SCHOOL

LICENSED PRESCRIBER MEDICATION ORDER FORM

Student Name: _____					**DOB:** _____
SECTION 1 – PRESCRIBER INFORMATION					
1. Licensed Prescriber's Name: _____					
2. Title:	☐ **MD**	☐ **DO**	☐ **NP**	☐ **PA**	☐ **Other:** _____
3. Business Phone: _____					**Fax:** _____
SECTION 2 – MEDICATION INFORMATION					
1. Child's Diagnosis: _____					
2. Medication Name: _____					
3. Dose: _____					**Frequency:** _____
3. Route:	☐ **PO**	☐**Inhaled**	☐ **IM**	☐ **SC**	☐ **Other:** _____
4. Possible Side Effects: _____					
5. Action to be Taken In Case of Side Effects: _____					
6. Special Instructions: _____					
Date: _____					**Prescriber's Signature:** _____
Please return this form to: Christ Lutheran School Office, (310) 831-0848 x3 or fax (310) 831-0090					