TOWN OF FAIRFIELD HEALTH PROGRAM
MEDICATION AUTHORIZATION FOR STUDENT WITH SEVERE ALLERGIC REACTION (FOOD, INSECT, LATEX, ENVIRONMENTAL, OTHER)

Name of Student_____Date of Birth_____

Specific Allergen_____

Please prescribe two auto-injectors for child to have in school if repeat dose is ordered.

A. Epipen Administration (CHOOSE EITHER #1 or #2)

1. Administer epinephrine immediately if child knowingly and/or suspects he/she was exposed to the allergen.

a. Check one: □ Epinephrine 0.3mg IM or SC Epipen Auto-Injector □ Epinephrine 0.15mg IM or SC Epipen Jr. Auto-Injector

b. Side-effect/plan for management _____

2. Administer epinephrine if symptoms of anaphylaxis occur.

a. Check one: □ Epinephrine 0.3mg IM or SC Epipen Auto-Injector □ Epinephrine 0.15mg IM or SC Epipen Jr. Auto-Injector

b. Side-effects/plan for management _____

____Repeat x 1 in 10 minutes as needed for symptoms of allergic reaction.

CALL 911 WHENEVER EPINEPHRINE IS ADMINISTERED.

B. Please complete if an Antihistamine is part of the treatment plan for this student.

1. Drug name (**Brand and Generic**) _____
2. Dose _____
3. Route _____
4. Frequency _____
5. Administer (check one)
   ____ immediately following administration of epinephrine (see above).
   ____ at the time of actual exposure or suspected exposure to allergen in the absence of symptoms. Continue to observe for symptoms of anaphylaxis.
   ____ for non-threatening allergic reaction i.e., rash. Continue to observe for symptoms of anaphylaxis.

Side-effects/plan for management _____

Students may self-administer medications(s)___Epipen ____Antihistamine.

Self-administration means that the student will carry and administer his/her medication(s) without assistance.

Duration of Order(s): from _____to _____(date)

_____M.D./D.O./D.D.S./A.P.R.N./P.A./O.D.
Signature Date

_____
Address Telephone Fax

TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM
AUTHORIZATION OF PARENT OR GUARDIAN FOR
ADMINISTRATION OF MEDICATION IN SCHOOL

Connecticut State Law requires the written medication order of a physician or dentist licensed to practice in the United States or an Advanced Practice Registered Nurse, Physician's Assistant or Optometrist licensed to practice in Connecticut, and parent or guardian's written authorization for medications to be administered in school. All medications, prescription and non-prescription, shall be stored in their original container. All medications, except those approved for transporting by students for self-medication, shall be delivered to the school by the parent or guardian or other responsible adult. No more than a 3 month supply of medication may be kept at school. Medication will be administered by the School Nurse or other trained school personnel or by the student if he/she has been approved to self-administer the medication.

Name of Student_____ Date of Birth_____

School_____ Grade_____

Medication_____

I hereby give my permission for my child to receive the above medication in school as ordered by his/her physician or other authorized prescriber.

Self –administration of medication means that the student will carry and administer his/her medication without assistance.

Student may self-administer the above medication: (circle one): Yes No

I give my permission for communication between the school nurse and prescriber of this medication as needed for implementation of this medication order in school.

I authorize that this medication be **destroyed** if it is not picked up within one week following termination of the medication order or by dismissal on the last day of school, whichever comes first.

_____	_____	_____
Date	Signature of Parent or Guardian	Telephone

_____
Print Name of Parent or Guardian

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SHM Vol. II, Sec. 3, Medications/Spec.Hlth.Care Needs