**EPI PEN ADMINISTRATION and CARE PLAN**
Redondo Beach Unified School District

**School Year:** _____ **School:** _____ **Phone:** _____ **FAX:** _____

**Student:** _____ **DOB:** _____ **Grade/Room:** ☐/☐

**Diagnosis (specify):**
**ALLERGENS (specify)**
**SEVERE** _____

**MILD** _____
Has Epi Pen ever been used? NO ☐ YES ☐ AGE: _____

Place photo here

## Medication Orders

| Name and form of medication | Dosage prescribed | Indication / schedule |
|---|---|---|
| **ANTIHISTAMINE/** Benadryl or _____ | _____ ml liquid or perfect measure 12.5mg/5ml<br>_____ thin strips 12.5 mg/strip<br>_____ chewable tablets, 12.5mg/tablet<br>_____ 25 mg/capsule/tablet | |
| **EPI PEN** | _____ Epi Pen (.3mg) _____ Epi Pen JR (.15mg)<br>_____ Twinject _____ Twinject JR | |
| | | |
| | | |

Special Instructions: _____

**MILD REACTION**: hives, itching, sneezing, swelling of the face or extremities or if the allergen has been ingested but no symptoms

***What to do:***

- Administer **Antihistamine** if ordered.
- Call Parent to take home for further observation / Monitor for progression of signs to severe reaction

**SEVERE REACTION: DIFFICULTY BREATHING OR SWALLOWING** severe symptoms may include: itching, tingling or swelling of the lips, tongue, or throat, nausea, abdominal cramps, vomiting, diarrhea, tightening of throat, hoarseness, coughing, wheezing, nasal flaring, shortness of breath

***What to do:***

- SUMMON HELP, ADMINISTER **EPI PEN**
- ADMINISTER BENADRYL and/or other antihistamine (if not already given and student can swallow)
- **CALL 911** Parent, Principal, District Nurse
- ONE PERSON STAY WITH STUDENT

**Teacher will notify the Health Office two weeks prior to field trips or off campus activities/sporting events for detailed instruction on medication administration.**

PARENT STATEMENT:

☐ I hereby request that a school employee store and administer the medication(s) named above per the physician's order

☐ My child (grade 9 and above or under special circumstances agreed upon with district nurse) may carry and is trained to self administer the above medication without adult supervision. I understand and accept that no direct monitoring will be conducted by the school staff. I understand that it is strongly encouraged to have back up medication stored in the school health office.

I agree to provide the medication(s) named above and replacement medication(s) in container(s) labeled by the pharmacy and a change of label if dosage is changed; a new authorization for new medication(s) or changes in the dosage of the medications listed. I understand that it is the Parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician or medication occurs. I give my consent for the district nurse to communicate with the physician and to counsel with school personnel regarding my child.

**These orders expire at the end of the school year and must be renewed at the beginning of each school year.**

Parent Name: _____ Home Phone: _____ Work/Cell: _____

Emergency Contact: _____ Home Phone: _____ Work/Cell: _____

_____
**Parent Signature** **Date**

_____
**Physician Signature** **Date**

Office Address/Phone Stamp Required

5/2011db