

OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON

**EPINEPHRINE AUTHORIZATION
FOR USE WITH ANTIHISTAMINE AUTHORIZATION AND ALLERGY ACTION PLAN**

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART I TO BE COMPLETED BY PARENT OR GUARDIAN			
<p>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</p> <p>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.</p>			
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.			
<p>Emergency epinephrine injections may be administered by trained non-health professionals. These persons are prepared by licensed health care personnel to administer the injection. For this reason, only pre-measured doses of epinephrine (auto injector) may be given.</p> <p>After report of student exposure to _____, via (route of exposure) <input type="checkbox"/> Ingestion <input type="checkbox"/> Skin contact <input type="checkbox"/> Inhalation <input type="checkbox"/> Insect bite or sting the following action will be taken; _____ (specific allergens)</p> <p><input type="checkbox"/> The following injectable epinephrine dosage will be given immediately, as prescribed below.</p> <p><input type="checkbox"/> The following injectable epinephrine dosage will be given as noted below and as detailed on the attached Allergy Action Plan (F-4A), in conjunction with the Antihistamine Authorization Form (F-4B)</p>			
<p>Check <input checked="" type="checkbox"/> appropriate boxes:</p> <p><input type="checkbox"/> EpiPen 0.3 <input type="checkbox"/> Teva Generic EpiPen 0.3 <input type="checkbox"/> Impax 0.3 <input type="checkbox"/> Auvi-Q 0.3</p> <p><input type="checkbox"/> Give the pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution (0.3cc) by auto injection intramuscularly in anterolateral thigh.</p> <p><input type="checkbox"/> Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)</p> <p><input type="checkbox"/> EpiPen Jr. 0.15 <input type="checkbox"/> Teva Generic EpiPen 0.15 <input type="checkbox"/> Impax 0.15 <input type="checkbox"/> Auvi-Q 0.15</p> <p><input type="checkbox"/> Give the pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution (0.3 cc) by auto injection, intramuscularly in anterolateral thigh.</p> <p><input type="checkbox"/> Repeat the dose in 15 minutes if EMS has not arrived. (Two pre-measured doses will be needed in school.)</p>			
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	
<p>Check <input checked="" type="checkbox"/> appropriate box:</p> <p><input type="checkbox"/> I believe that this student has received adequate information on how and when to use an epinephrine auto injector, and has demonstrated its proper use.</p> <p style="margin-left: 40px;">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.</p> <p style="margin-left: 40px;">b. One additional dose, to be used as backup, should be kept in clinic or other school location.</p> <p><input type="checkbox"/> The auto injector will be kept in the school clinic or other school approved location _____.</p>			
_____ 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

Revised 2019

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 in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual.**
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. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **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 (e.g. inhaler, autoinjector). 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

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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 in the original, small, sealed container with the name of the medication and expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
 - a. Name of student
 - b. Exact dosage to be taken in school
 - c. Frequency or time interval dosage is to be administered
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.