Epi-Pen Form

CHIPPEWA VALLEY SCHOOLS

19120 Cass Avenue, Clinton Township, MI 48038

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"Chippewa Valley Schools…preparing students today for the challenges of tomorrow"

Student: _____ Birth Date: _____ Grade/Room: _____

Allergic to: _____

Asthmatic: Yes* _____ No _____ *Higher risk for severe reaction

The following exposure routes are known or suspected of causing a reaction: ___ ingestion

___ touch ___ inhalation

STUDENT PICTURE

STEP 1: TREATMENT FOR REACTION **(To be completed by Physician/Nurse Practitioner ONLY)****

IF SYMPTOMS ARE…….	GIVE MEDICATION CIRCLED	
If a student has been stung by an insect but no symptoms	Epi Pen	Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	Epi Pen	Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	Epi Pen	Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	Epi Pen	Antihistamine
Throat+: Tightening of throat, hoarseness, hacking cough	Epi Pen	Antihistamine
Lung+: Shortness of breath, repetitive coughing, wheezing	Epi Pen	Antihistamine
Heart+: Thready pulse, low blood pressure, fainting, pale blue color	Epi Pen	Antihistamine
If reaction is progressing (several of the areas affected)	Epi Pen	Antihistamine

+ These symptoms are potentially life threatening and can change quickly.

Dosage

Circle one Epi Pen Epi Pen Jr. (See reverse side for instructions on how to administer Epi Pen)

Antihistamine (name and dosage): _____

Other medication (name and dosage): _____

Step 2: EMERGENCY CALLS

1. Call 9-911 – If the Epi Pen is given. Inform EMS operator that an Epi Pen has been given to treat a severe allergic reaction and request transport to a hospital.
2. Call Dr. _____ at _____
3. _____ _____
   PARENT A **HOME/WORK/CELL #**
4. _____ _____
   PARENT B **HOME/WORK/CELL #**
5. Emergency contacts if unable to reach parent:
   Name/Relationship Home/Work/Cell #

   _____ _____

   _____ _____

I recommend that the medications indicated above be given as directed to this student.

_____ _____
PHYSICIAN NAME **DATE**

_____ _____
PHYSICIAN SIGNATURE **TELEPHONE/FAX NUMBER**

1. I request that Chippewa Valley Schools' staff administer the medications prescribed per the physician's directions and request that my child be taken by EMS to a hospital for further evaluation and treatment.
2. I will assume responsibility for safe delivery of the medication to school by myself or an adult.
3. I will notify the school immediately if there is any change in the use of the medication of the prescribed treatment.
4. I will release and agree to hold the Board of Education, its officials, its employees, and its third party contracted individuals harmless from any and all liability, foreseeable and unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**