Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 1

(Parent/guardian signature required on Part 2). A completed form must be provided before the student may possess and use an epinephrine autoinjector to alleviate anaphylaxis in schools.

Student Photo (Must attach)

A			
Student name	❑ Male ❑ Female Date of birth	Student address	Student ID#
Grade/Class	Teacher	School	Height/Weight (optional)

Medication order in this section must be signed by the licensed prescriber

Medication Name and Start/End Date	Dosage Route and Time Interval (Specify signs, symptoms or situations)	Possible Severe Adverse Reactions	Special Instructions (Choose all that are appropriate)
❑ See Allergy Action Plan 1 Extremely reactive to the following foods (allergen):_____ _____ _____ **1. Medication** ❑ EpiPen® Autoinjector ❑ EpiPen® Jr Autoinjector ❑ Other epinephrine autoinjector _____ _____ Diagnosis: _____ Begin Date: _____ End Date (if known): _____	**Time** 2 • If checked below, give ordered epinephrine immediately for ANY symptoms if the allergen was likely eaten. • If checked below, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted • Other _____ **Standard Order (Intramuscular or subcutaneously into the anterolateral aspect of the thigh) PRN for** ❑ **EpiPen®** 0.3 mg/0.3 ml, (2 ml) 1:1000 sterile solution, delivers 0.3 mg per injection ❑ May repeat in 15-20 minutes ❑ **EpiPen® Jr** 0.15 mg/0.3 ml, (2 ml) 1:2000 sterile solution, delivers 0.15 mg per injection ❑ May repeat in 15-20 minutes Note: EpiPen® & EpiPen JR® each contain 2mL epinephrine solutions. Approximately 1.7 mL remain in the autoinjector after use and cannot be reused. ❑ **Other epinephrine autoinjector medication** _____ ❑ Twin pak Dose _____ ❑ May repeat in 15-20 minutes 2. **Call 911** (per law if autoinjector used) 3. Begin monitoring	**Possible Severe Adverse Reactions per ORC 3313.718:** 3 ❑ To the student for whom it is prescribed (that should be reported to the physician) _____ _____ ❑ To the student for whom it is **NOT** prescribed who receives a dose _____ _____ ❑ Other _____ _____	**Special Instructions** 4 ❑ As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector. **(Parent must also sign Part 2)** ❑ Backup dose is ordered (parent will provide a backup dose of the medication to the school principal or nurse as required by law) ❑ **Procedures to follow if the medication does not produce the expected relief** _____ _____ ❑ **Procedures to follow if student is unable to administer anaphylaxis medication** _____ _____ ❑ Store medication in school health room and student to self-administer under observation ❑ Store medication in school health room and nurse or school staff to administer in emergency **Other** _____
2. Medication _____ Diagnosis: _____ Begin Date: _____ End Date (if known): _____	❑ **Standing Daily Dose** **Specify Time** _____ am **and/or** ❑ prn _____ **Time Interval** every (q) _____ hours as needed _____ _____ (specify signs, symptoms or situations)	**Possible Severe Adverse Reactions Reportable to Prescriber** _____ _____ _____	**Special Instructions** ❑ Store medication in school health room and nurse to administer ❑ Requires refrigeration ❑ Other _____ _____
3. Medication _____ Diagnosis _____ Begin Date _____ End Date (if known) _____	❑ **Standing Daily Dose** **Specify Time** _____ am **and/or** ❑ prn _____ **Time Interval** every (q) _____ hours as needed _____ _____ (specify signs, symptoms or situations)	**Possible Severe Adverse Reactions Reportable to Prescriber** _____ _____ _____	**Special Instructions** ❑ Store medication in school health room and nurse to administer ❑ Requires refrigeration ❑ Other _____ _____
List Home medication(s) _____ _____ 5 _____ _____ _____	**Prescriber** (please print) 6 _____ **Prescriber address** _____ _____	**Prescriber signature/date** 6 _____ **Prescriber Emergency phone** _____ **Fax** _____	**For Nurse Use Only: (Revision per Licensed Nurse after consultation with prescribing provider)** _____ _____

Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 2

Prescriber order(s) and signature required on Part 1. A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector in school to alleviate allergy symptoms

Student Information

A

Student name	Date of birth
Student address	Grade/Classroom

Parent/Guardian Authorization

B

- ☑ I authorize a designated employee of the school board to administer the prescribed medication as ordered for my child
- ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed
- ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist should a question come up about the medication
- ☑ Medication and medication form must be received by the principal, his/her designee or the school nurse
- ☑ I understand that the medication must be in the **original container** and be **properly labeled** with the student name, prescriber name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate
- ☑ By law, I agree that it is important to keep a back up epinephrine autoinjector at the school's designated location
- ☑ I understand I must to come into the school office/clinic when my child's medication is discontinued by the prescriber or at the end of the school year, or medication will be disposed of one week post-discontinuation orders or school year end

Parent/Guardian signature	Date	#1 contact phone ( )	#2 contact phone ( )

Self-Carry Authorization

C

Parent must ☑ below to indicate student is allowed to self-carry their epinephrine autoinjector

- ❑ I authorize and recommend self-medication by my child for the prescribed listed medication
- ❑ I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending prescriber

Parent/Guardian signature	Date	#1 contact phone ( )	#2 contact phone ( )

Do not write below (For school staff only)

D

Reviewed by	Title/Position	Date
Comments		

❑ File per district policy