39513036

Howard County Public Schools
Epinephrine Auto-Injector Order Form/Care Plan

Medication Form for Students with Allergic Reactions - To be completed by physician/authorized prescriber

Name: _____ Gender: M F School/Grade:_____ DOB:_____

Student Allergies:

Known Triggers: ☐ Ingestion ☐ Touch ☐ Sting ☐ Other (list) _____

Date of Order: _____ ***Order Valid for Current Year including Summer School, unless otherwise indicated:*** _____

Physician/Prescriber Signature: _____ Phone: _____

Physician/Prescriber: Print Name _____ Fax: _____

Parent/Guardian Signature: _____ Phone: _____

Parent/Guardian: Print Name _____ Cell Phone: _____

Epinephrine Auto-Injector Order

Dose: **(Circle one)** 0.15mg 0.30mg

Student is able to self-administer: YES NO

Student may carry auto-injector on self: YES NO

(A back-up auto-injector must be kept in Health Room)

Date Epinephrine Auto-Injector Expires:

Possible Side Effects: _____

Oral Medication Order

Medication: _____

Dose: _____

Strength: _____

Frequency: _____

Date Medication Expires: _____

Possible Side Effects: _____

Student Photo

Administration Choices (please check all that apply):

_____ Administer _____ for known or possible ingestion/touch/sting/other (list) _____.
(oral medication)

_____ Prior to onset of symptoms

_____ If student develops hives, rash, itchy mouth or other symptom(s) (list)_____

_____ After Epinephrine Auto-injector is given

_____ Give Auto-Injector Epinephrine for know or possible ingestion/touch/sting/other _____ of _____.

_____ Prior to onset of symptoms

_____ At first sign of any symptoms (see back for list)

_____ Only if student develops throat/lung/heart symptoms or if two or more body systems are involved (see back for list)

Other Instructions: _____

_____

_____

_____