PHYSICIAN MEDICATION ORDER FOR MANAGEMENT OF KNOWN ANAPHYLAXIS

Attach Photo	Student Name:	Date of Birth:
	School:	Grade:
	Order Valid for School Year _____(including summer)	

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Administer Epinephrine for Exposure to the Following Allergen(s): _____

☐ insect sting/bite _____ ☐ ingestion ☐ contact
☐ unknown etiology (specify signs/symptoms):

When to Administer Epinephrine: (choose one)

☐ Administer epinephrine immediately. Do not wait for signs/symptoms.

☐ Administer epinephrine if ***1 or more*** of the following signs/symptoms are present:

Lung: *difficulty breathing, repetitive/hacking cough, audible wheezing*
Skin: *many hives over the body*
Throat: *itching and/or tightness of throat, difficulty swallowing*
Stomach: *diarrhea, stomach pain and/or cramping, vomiting*
Mouth/Face: *swelling and/or tingling of lips, tongue, mouth, swelling of eyes*

A second dose will be administered in 5-10 minutes if EMS has not arrived and symptoms continue, worsen, or resolve/lessen and then return.

Epinephrine Dosage Ordered: Single Dose Auto-injector ☐ 0.15mg IM ☐ 0.30mg IM

Possible side effects: palpitations, rapid heart rate, sweating, nausea, vomiting
Other:

Student is competent to self-carry ☐ No ☐ Yes Student is competent to self-administer ☐ No ☐ Yes

If competent to self-carry /self-administer, parent must complete section on the back of this form

Healthcare Provider Name (print)	Date:
Healthcare Provider Signature:	
Phone:	Fax:

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to standard school policy. I release Meritus Health, the Washington County Board of Education, and their employees from any claim or liability for administering prescribed medication to this student. I have read the information on the back of this form and assume the responsibilities as stated on this form. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Name (print):	Date:
Parent/Guardian Signature:	Daytime Phone:
	Other Phone:

The following medication guidelines are used in Washington County Public Schools. These guidelines enable the school health staff to provide the best possible service to your child.

Order reviewed by the School Health RN _____ Date: _____

Medication Guidelines

1. In order for medication to be given at school, the medication must be accompanied by a properly completed *Physician Medication Order for Management of Known Anaphylaxis* form.
2. The school nurse will call the prescriber as allowed by HIPAA if a question arises about the child and/or the child's medication.
3. Prescription medication(s) must be in a container labeled by the pharmacist with the student's name, prescriber's name, name of medication, dosage, route, directions for administration, conditions for storage, prescription date and expiration date. Maryland law allows prescription medication to be used either 1 year beyond date of issue or by the expiration date indicated on the medication—whichever comes first.
4. An adult must bring the medication to school. No medication will be sent home with a student.
5. All medication must be picked up by an adult at the end of the school year. NO medication will be sent home with your child.
6. If the health care provider indicates that the student is competent to self-administer and/or self-carry, the school registered nurse shall then certify that the student possesses the skills and maturity necessary to self-administer and/or self-carry in the school setting.
7. If the health care provider and school registered nurse both determine that the student is capable to self-carry and/or self-administer, the principal and school registered nurse shall establish procedures for the student to self-carry and/or self-administer. The principal, school registered nurse, parent/guardian, student (if appropriate), and the health care provider may be asked to provide input into the self-carry/self-administer procedures that are most appropriate for the student. The principal and/or school registered nurse may revoke the authority of a student to self-carry medication if the student fails to follow the proper procedures, rules, and regulations for self-carry/self-administration, including if the student endangers anyone through the misuse of the medication.
8. The *Physician Medication Order for Management of Known Anaphylaxis* form must be reviewed and signed by the school RN before medication administration can begin. The school RN is allowed at least 2 school days to review and sign the order.

Self-Carry/Self-Administration of Emergency Medication Contract

This section must be completed for students to self-carry/self-administer prescribed emergency medication.

1. Student has demonstrated the purpose, appropriate method, and time to administer the epinephrine auto injector to the nurse.
2. Student agrees to never share the medication with another student.
3. Student will have someone notify the health office immediately if he/she self-administers the epinephrine auto injector.

The student may be subject to disciplinary action if he/she does not carry/use the medication in a safe and proper manner.

Student Signature:	Date:
School Nurse Signature:	Date:
School Administrator Signature:	Date:

I give my permission for my child (name) _____to carry the epinephrine auto-injector as prescribed by the health care provider. I understand that he/she must follow the rules listed above. I will notify the health office of any changes to my child's medication or medical condition.

Parent/Guardian Name (print):	
Parent/Guardian Signature:	Date: