



PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS

Prescriber's Medication Order Form

Emergency Medication-EPI-PEN

THIS IS A LIFE THREATENING EVENT

This order is valid ONLY for school year (current) \_\_\_\_\_ including the ESY/summer session.

Name of School: \_\_\_\_\_

FOR COMPLETION BY PARENT(S)/GUARDIAN(S):

Full Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Known Allergies:  None  Specify: \_\_\_\_\_

- I hereby authorize the medication described below to be administered as directed by my child's health care prescriber.
I understand that the prescriber will be called if a question arises about my child's medication as allowed by HIPAA.
I understand that ALL medications must be labeled with the name of the medication, name of the student, name of the prescriber, date, and directions for administration and prescription medication(s) must be labeled by a registered pharmacist.
I understand that I must supply the school with the equipment/supplies needed to administer the medication.
I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.
I understand 911 will be called immediately

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_

FOR COMPLETION BY PRESCRIBER (ANAKIT WILL NOT BE ACCEPTED)

School personnel will be taught by a registered nurse to administer the epipen. These individuals are non-medical school staff. Medical orders MUST be clear and explicit as to when the epipen is to be given. These personnel will NOT make medical judgments or observe for medical symptoms.

Medication Name: EPIPEN (EPINEPHRINE AUTO INJECTOR)

Dose:  Epipen 0.15 mg  Epipen 0.30 mg Route: Auto injection into anterolateral aspect of the thigh

Reason for (check one):  Stinging Insect  Ingestion of: \_\_\_\_\_  Other: \_\_\_\_\_

Medication is to be given (check one):  Immediately after insect sting  Immediately after ingestion of: \_\_\_\_\_
(Please Note: 911 WILL BE CALLED IMMEDIATELY AFTER ADMINISTRATION)

Side Effects: \_\_\_\_\_

Date medication began: \_\_\_\_\_ Date medication discontinued: \_\_\_\_\_

Is student capable of self-administering the Epipen?  Yes  No

Should student carry the Epi-pen with him/her during the school day?  Yes  No

Does Epipen administration instructions need to be reviewed with this student?  Yes  No

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Original Signature or signature stamp only)

Prescriber's Name/Title: \_\_\_\_\_ Address: \_\_\_\_\_

(Please print or type)

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self-carry/self-administration of emergency medication MUST be authorized by the prescriber and supported by the school nurse's assessment according to Medication Administration policy #5163. \*\*\* self-carry and self-administer:  Yes  No Signature of PGCPs RN/LPN: \_\_\_\_\_

Order reviewed by RN/LPN: \_\_\_\_\_ Date: \_\_\_\_\_