

# EpiPen Administration ALLERGY Emergency Action Plan

## CALL 911.....

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_



Remove the device from the plastic protective container.



Remove the *grey cap* from the fatter end of the device.

**NB: This "arms the unit" ready for use**



**Hold** the EpiPen in your fist with clenched fingers wrapped around it

**(NB: there is nothing to "push" at the white end)**

Press the *black tip* gently against the skin of the mid thigh, then start to push harder until a loud "click" is heard. **This means that the device has been activated.**

Hold in place for 10-15 seconds (count "1 elephant, 2 elephants, 10 elephants etc") while the adrenaline is injected under pressure.

**NB: The EpiPen "pop" is often quite loud.**

**Madison County School Health Program**  
**Permission Form for Prescribed and Over the Counter Medication**

**TO BE COMPLETED BY SCHOOL PERSONNEL**

School: \_\_\_\_\_ Date form received: \_\_\_\_\_  
 I/we acknowledge receipt of this Physician's Statement and Parent Authorization. \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Student age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Grade:** \_\_\_\_\_ **Homeroom/Classroom:** \_\_\_\_\_

**TO BE COMPLETED BY PARENT / GUARDIAN**

\*\*\*\*\***(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)**\*\*\*\*\*

**Name of medication:** \_\_\_\_\_  
**Reason for medication:** \_\_\_\_\_  
**Form of medication/treatment:** \_\_\_\_\_  
 Tablet/capsule    Liquid    Inhaler    Injection    Nebulizer    Other \_\_\_\_\_

**Instructions** (Schedule and dose to be given at school: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Start:    Date form received    Other, as specified: \_\_\_\_\_  
 Stop:    End of school year    Other date/duration: \_\_\_\_\_  
 **For episodic/emergency events only**

**Restrictions and/or important side effects:**    No restrictions  
 Yes. Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Special storage requirements:**    None    Refrigerate  
 Other Instructions: \_\_\_\_\_

**Parent or Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Health Care Provider Name \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

I give permission for (name of child) \_\_\_\_\_ is to receive the above stated medication at school according to standard school policy. I release the Madison County School Board and its employees from any claims or liability connected with its reliance on this permission.  
**(Parent/guardians to bring the medication in its original container.)**  
**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Home phone:** \_\_\_\_\_ **Work phone:** \_\_\_\_\_ **Emergency or CELL phone:** \_\_\_\_\_

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**EMERGENCY MEDICATION AUTHORIZATION**

This student is capable, responsible, and demonstrated self-administration of the above medication: **to be completed for asthmatic, diabetic or severe allergy ONLY**  
 **Yes - Unsupervised**    **Yes-Supervised**    **No**  
 This student may carry this medication:    **Yes**    **No**   **Any restriction(s):** \_\_\_\_\_  
**The school nurse will delegate and train designated school personnel to give the above stated emergency medication.**  
**Please indicate if you have provided additional information:**  
 On the back side of this form    As an attachment  
 Signature: \_\_\_\_\_ Date \_\_\_\_\_  
**Physician or Authorized Provider**