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: _______________________