



PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS

Prescriber's Medication Order Form

Emergency Medication-EPINEPHRINE

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

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

Medication Name: **EPINEPHRINE (EPINEPHRINE AUTO INJECTOR)**

Dose: Epinephrine 0.15 mg Epinephrine 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 Epinephrine? Yes No

Should student carry the Epinephrine with him/her during the school day? Yes No

Does Epinephrine 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: _____