Government of the
District of Columbia
Adrian M. Fenty, Mayor

ACTION PLAN FOR ANAPHYLAXIS

Patient's Name		Date of Birth	Expiration Date for Medication Plan
Health Care Provider		Provider's Phone Number	
Responsible Person (i.e., parent/guardian)		Phone Number	
Emergency Contacts	Home Telephone Number	Work Number	Cellular Number
1.			
2.			
Patient's known allergies:			

WATCH FOR SIGNS AND SYMPTOMS OF ANAPHYLAXIS

Medication:

To prevent anaphylaxis shock administer a one-time injection in thigh or specify other location.

____

☐ EpiPen Jr. (0.15 mg)

☐ EpiPen (0.3 mg)

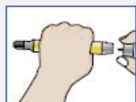
☐ Other ______________________

Only a few signs and symptoms may be present. Severity of symptoms can change quickly. Some symptoms can be life threatening:

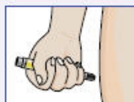
- **Rash (especially hives) with redness and swelling (especially on face, lips and tongue)**
- **Shortness of breath, cough, wheeze**
- **Difficulty talking and/or hoarse voice**
- **Abdominal pain, vomiting, diarrhea**
- **Loss of consciousness**

ACT QUICKLY !!!!!

How to give EpiPen® or EpiPen® Jr (can be administered through clothing)

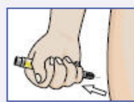


1. Form fist around EpiPen® and pull off grey cap.



2. Place black end against outer mid-thigh.

3. Push down **HARD** until a click is heard or felt and hold in place for 10 seconds.



4. Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.

1. **Stay with the child and have someone call 911.**
2. **Locate EpiPen (epinephrine).**
3. **Oversee or assist child in injecting the epinephrine in thigh using medication listed above.**
4. **Contact responsible person or other emergency contacts listed above.**

SCHOOL MEDICATION CONSENT AND PROVIDER ORDER FOR CHILDREN AND YOUTH:

Healthcare Provider's Initials

________________This student was trained and is capable to self-administer with the auto injectable epinephrine pen.

________________This student is not approved to self-medicate.

____ ______________________

Health Care Provider's Signature **Date**

❑ As the Responsible Person, I hereby authorize a trained school employee to administer medication to the student.

❑ As the Responsible Person, I hereby authorize this student to possess and self-administer medication.

❑ As the Responsible Person I understand this student is not authorized to self-administer medication.

As the Responsible Person, I agree that the school and its employees and its agents shall incur no liability and shall be held harmless against any claims that may arise relating to the administration, supervision, training, or self-administration of medication.

____ ______________________

Responsible Person's Signature Date

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DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH
SCHOOL HEALTH PROGRAM
STUDENT HEALTH AUTHORIZATION FORMS

Name of Student: ______________________ Date of Birth: ______________________
School: ______________________________ Social Security #: ____________________
Grade: ______________

PART I: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: *Please complete and sign this form.*

I hereby request and authorize the school nurse/licensed practical nurse/certified DCPS personnel to administer prescribed medications as directed by the physician to my son/daughter.

____
Student's Name

I have received and read a copy of the procedures for medication authorization and agree to assume responsibilities as required. This medication is a __________ new or __________ renewed prescription. *If this is a new prescription, enter the date and time of first dose given at home.*

Date: ____________________ *Time:* ____________________ *A.M.* ______ *P.M.* ______

Name of Parent/Guardian: ______________________________ Date: ______________
Please Print

______________________________ ______________________________
Signature of Parent/Guardian Relationship

Please take this form to the student's physician for completion

PART II: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: *Please complete and sign this medication authorization order.*

Please check one: ________ *Original* ________ *Renewal* ________ *Change*

Name of Student: ______________________ Date of Birth: ______________________
Diagnosis: ______________________ Telephone #: ______________________
Name of Medication: ____
Dose: ____
Time and circumstances of administration at school: ______________________
Expected duration of administration: ______________________
Can reaction be expected? _____Yes _____No If yes, please describe: ______________
____
Physician's Name: ____
Physician's Address: ____
Telephone Number: ____
Physician's Signature: ______________________ Date: ______________

______________________________ ______________________________
School Nurse DCPS Qualified Staff

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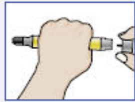

1. Form fist around EpiPen® and pull off grey cap.

2. Place black end against outer mid-thigh.

3. Push down **HARD** until a click is heard or felt and hold in place for 10 seconds.

4. Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.

1. **Stay with the child and have someone call 911.**
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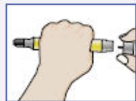

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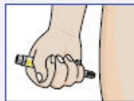

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