



Banner Christian School

P.O. Box 74010
North Chesterfield, Virginia 23236
Phone: 804-276-5200
Fax: 804-276-7620
www.bannerchristian.org

EPINEPHRINE AUTHORIZATION

FOR USE WITH ANTIHISTAMINE AUTHORIZATION AND ALLERGY ACTION PLAN

PART I – TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request school MAT personnel or other designated school personnel to administer an epinephrine injection as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for administering these injections, provided the designated school personnel comply with the Licensed Healthcare Provider or parent/guardian orders set forth in accordance with the provision of Part II below. I am aware that the injection may be administered by a specifically authorized and trained non-health professional. I have read the procedures outlined on the back of this form and assume responsibility as required.

I understand that emergency medical services (EMS) will ALWAYS be called when Epinephrine is given, whether or not the students manifests any symptoms or anaphylaxis, and that the student will be required to go to the Emergency Room via Rescue Squad.

Student Name (last, first, middle): _____ **Date of Birth:** _____

Grade: _____ **School Year:** _____ **Allergies:** _____

PART II – TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER WITH NO ABBREVIATIONS

Emergency Epinephrine injections may be administered by authorized and trained non-health professionals. These persons are prepared by licensed health care personnel to administer the injection. For this reason, only pre-measured doses of Epinephrine (auto injector) may be given.

After report of student exposure to (specific allergens) _____

Route of exposure: Ingestion Skin Contact Inhalation Insect bite or sting

The following action will be taken: (check one only)

- The following injectable epinephrine dosage will be given **IMMEDIATELY** as prescribed below
 The following injectable epinephrine dosage will be given as noted below and as detailed on the attached Allergy Action Plan, in conjunction with the attached Antihistamine Authorization Form.

Check appropriate medication/dosage/instructions:

EpiPen 0.3 mg Twinject 0.3 mg Adrenaclick 0.3 mg Auvi-Q 0.3 mg
 Give the pre-measured dose of 0.3 mg epinephrine 1:1000 aqueous solution (0.3cc) by auto injection intramuscularly in anterolateral thigh
 Repeat the dose in 15 minutes if EMS has not arrived. (two pre-measured doses will be needed at school)

EpiPen Jr. 0.15 mg Twinject 0.15 Adrenaclick 0.15 mg Auvi-Q 0.15 mg
 Give the pre-measured dose of 0.15 mg epinephrine 1:2000 aqueous solution (0.3cc) by auto injection intramuscularly in anterolateral thigh
 Repeat the dose in 15 minutes if EMS has not arrived. (two pre-measured doses will be needed at school)

COMMON SIDE EFFECTS: Increased heart rate, stronger or irregular heartbeat, sweating, nausea, vomiting, feeling weak, feeling anxious

Effective Date: _____ If the student is taking more than one medication at school, list sequence the inhalers are to be taken.

Start Date: _____ End Date: _____ Date Parent to Pick-up from School: _____

Check appropriate statement:

The student's epinephrine auto injectors are to be kept in the school health office or other school approved location.

I certify that this child has a medical diagnosis of severe allergic reactions, has been trained in the safe use of the prescribed medication(s) and is judged to be capable of safely carrying and self-administering an epinephrine auto injector in school. The MAT personnel or appropriate school staff should be notified anytime the medication/injector is used. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice. The student has medical permission to self-carry and self-administer epinephrine during school hours, subject to MAT trained personnel approval. A second dose is to be kept in the school health office or other designated school location. The student is aware that the school may withdraw permission to possess and self-administer epinephrine at any point during the school year if the student has abused the privilege of possession/self-administration or the student is not safely, reliably and effectively managing this medication.

_____ Licensed Health Care Provider (PRINT)	_____ Licensed Health Care Provider (Signature)	_____ Phone Number	_____ Date
_____ Parent/Guardian (PRINT)	_____ Parent/Guardian (Signature)	_____ Phone Number	_____ Date
_____ Student (Signature)	_____ Date		

EPINEPHRINE AUTHORIZATION continued

PART III – TO BE COMPLETED BY MAT PERSONNEL

Check as appropriate:

Parts I and II are complete, including signatures. (It is acceptable if all items in Part II are written on the LHCP stationery or prescription pad.)

Auto injectors are appropriately labeled and in original packaging.

_____ Date by which any unused auto injectors are to be collected by the parent. (Within one week after expiration of the physician order or the last day of school)

If applicable, I have reviewed the proper use of an auto injector with the student and I agree disagree that the student should self-carry epinephrine in school.

_____ MAT Personnel (PRINT)	_____ MAT Personnel (Signature)	_____ Date
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