

	ACTION PLAN	FOR ANAPHYLAX	Adrian M. Fenty, May		
Patient's Name		Date of Birth	Expiration Date for Medication Plan		
Health Care Provider		Provider's Phone Number			
Responsible Person (i.e., parent/guardia	nn)	Phone Number			
Emergency Contacts	Home Telephone Num	ber Work Number	Cellular Number		
1.					
2.					
Patient's known allergies:					
W.	ATCH FOR SIGNS AN	D SYMPTOMS OF ANAPI	HYLAXIS		
Medication:			ly a few signs and symptoms may be present. Severity of symptoms		
To prevent anaphylaxis show	ck administer a one-time	can change quickly. Some sym	iptoms can be life threatening:		
injection in thigh or specify		• Rash (especially hiv	ves) with redness and swelling		
		(especially on face,	lips and tongue)		
		• Shortness of breath			
EpiPen Jr. (0.15 mg)			Difficulty talking and/or hoarse voiceAbdominal pain, vomiting, diarrhea		
EpiPen (0.3 mg)		 Loss of consciousness 			
Other					
	ACT	QUICKLY !!!!!			
How to give EpiPen® or EpiPen® Jr (can be admini	stered through clothing)	4 0 11 1			
Creph en 71 (cui be dumini	Stered in ough clothing)		v		
		2. Locate EpiPen (epir	-		
around EpiPen® end against	. Push down ARD until a EpiPen® and be	3. Oversee or assist ch thigh using medicat	ild in injecting the epinephrine in ion listed above.		
grev cap.	lick is heard careful not to r felt and hold touch the needle. n place for Massage the	4. Contact responsible	person or other emergency		
1	0 seconds. injection site for 10 seconds.	contacts listed abov	e .		
SCHOOL MEDICATION CONSE	NT AND PROVIDER ORDER	FOR CHILDREN AND YOUTH:			
Healthcare Provider's Initials			This publication was supported by		
This student was trainedThis student is not appr	d and is capable to self-administer with the oved to self-medicate.	ne auto injectable epinephrine pen.	Cooperative Agreement Number U59/CCU324208-03 from the Centers for Disease Control and Prevention (CDC). Its		
			content is solely the responsibility of the authors and do not necessarily represent the		
Health Care Provider's Signatu		Date	official views of the CDC.		
As the responsible person, I hereby authorize			Permission to Reproduce Blank Form		
As the responsible person, I hereby authorize	•		GOVERNMENT OF THE DISTRICT OF COLUMBIA		
As the responsible person I understand this start has the responsible person, I agree that the schagainst any claims that may arise relating to	hool and its employees and its agents sha	all incur no liability and shall be held harmless			
			DEPARTMENT OF HEALTH		

Date

FEBRUARY 2008 PATIENT COPY

Responsible Person's Signature

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

Name of Student:		Da	te of Birth:	
School:	Social Security #:			
Grade:				
		HARDI	IAN CONSENT FORM	
Parent/Guardian: Please co	omplete and sign	this for	rm.	
I hereby request and authoriz to administer prescribed med				
	Stu	dent's l	Name	
I have received and read a coresponsibilities as required. The prescription. If this is a new prescription.	This medication i	is a	new or	renewed
Date:				
Name of Parent/Guardian	1:	Ple	Dace Print	ate:
		1 10	ase I IIIIt	
Signature of Parent/O	 Guardian	_	Relationship	
Please take this form to the	student's physi	ician fo	r completion	
PART II: PHYS	SICIAN'S MED	<u>ICATI</u>	ON AUTHORIZATION	N ORDER
Physician: Please complete	and sign this med	dication	authorization order.	
Please check one:				Change
	Date of Birth: Telephone #:			
Name of Medication:				
Dose:				
Time and circumstances of a	dministration 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			Date:	
Signature:				
School Nurse			DCPS Qualified Stat	ff



\mathbf{A}	CTION PLAN F	OR ANAPHYLA	AXIS Adrian M. Fenty, Mayo	
Patient's Name		Date of Birth	Expiration Date for Medication Fian	
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:				
WATC	H FOR SIGNS AND S	SYMPTOMS OF ANAI	PHYLAXIS	
Medication: Or sy		(especially on face, lips and tongue) Shortness of breath, cough, wheeze		
☐ EpiPen Jr. (0.15 mg)		• Difficulty talking a		
EpiPen (0.3 mg)		Abdominal pain, vomiting, diarrheaLoss of consciousness		
Other	_	2000 01 40110410410410		
	ACT OI	JICKLY !!!!!		
How to give EpiPen® or EpiPen® Ir (can be administered and pull off grey cap. 2. Place black end against outer mid-thigh. 3. Push de HARD unticlick is head in place for 10 second	own 4. Remove I a EpiPen® and be careful not to hold touch the needle. I Massage the	2. Locate EpiPen (epin 3. Oversee or assist chi thigh using medication	ild in injecting the epinephrine in listed above. person or other emergency	
SCHOOL MEDICATION CONSENT AN	D PROVIDER'S ORDER FO	OR CHILDREN AND YOUTH	:	
This student is not approved to s	apable to self-administer with the autoelf-medicate.	o injectable epinephrine pen.	This publication was supported by Cooperative Agreement Number U59/CCU324208-03 from the Centers for Disease Control and Prevention (CDC). Its content is solely the responsibility of the authors and do not necessarily represent the	
Health Care Provider's Signature	Date		official views of the CDC.	
As the Responsible Person, I hereby authorize a trained			Permission to Reproduce Blank Form	
As the Responsible Person, I hereby authorize this stu As the responsible person I understand this student is	•		GOVERNMENT OF THE DISTRICT OF COLUMBIA	
As the responsible person, I agree that the school and against any claims that may arise relating to the admir	its employees and its agents shall inco	ur no liability and shall be held harmles	DEPARTMENT OF HEALTH	

Responsible Person's Signature

Date



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.				
D 41 42 1 11 1		•	•	

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) \Box 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'S ORDER FOR CHILDREN AND YOUTH:

Healthcare Provider's Initials		This publication was supported by
This student was trained and is capable to self-administer with the auto injectable epinephrine pen.		Cooperative Agreement Number
This student is not approved to self-medicate.		U59/CCU324208-03 from the Centers for Disease Control and Prevention (CDC). Its content is solely the responsibility of the authors and do not necessarily represent the
Health Care Provider's Signature D	ate	official views of the CDC.
As the Responsible Person, I hereby authorize a trained school employee to administer	medication to the student.	Permission to Reproduce Blank Form
As the Responsible Person, I hereby authorize this student to possess and self-administra	er medication.	GOVERNMENT OF THE DISTRICT OF COLUMBIA
As the responsible person I understand this student is not authorized to self-administer		
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.		
		DEPARTMENT OF HEALTH
Responsible Person's Signature Da	te	