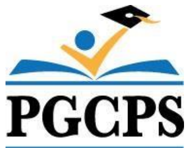

# PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS

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: ______________________

Revised 6/13