Wallington Public Schools

School Year_____

Physician's Orders for Administration of Epinephrine

Student's Name: _____ **DOB**_____

Allergy to: _____

Asthmatic Yes*_____ NO _____ *Higher risk for severe reaction

Symptoms:	**Give Checked Medication**:** **(To be determined by physician authorizing treatment)	
▪ If a food allergen has been ingested, but *no symptoms:*	☐ Epinephrine	☐ Antihistamine
▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin Hives, Itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ Other	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine	☐ Antihistamine

TREATMENT

Epinehprine: IM (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg

_____ May repeat dose in 15 minutes, if there is an inadequate response to intial dose.

_____ Student is both capable and responsible for administering this Epinephrine.

Antihistamine: give _____

Other: give_____

IN THE ABSENCE OF THE SCHOOL NURSE, THE ORDER FOR ANTIHISTAMINE SHOULD BE DISREGARDED AND EPINEPHRINE IS TO BE ADMINISTERED BY THE DESIGNEE.

ACTION

1. CALL: RESCUE SQUAD: Alert 911 to possible allergic reaction/epinephrine emergency.

2. CALL: Parents/Guardian or emergency contacts

3. CALL: Dr. _____ at _____

EMERGENCY CONTACTS

1. Mother's Name _____ Phone# _____

2. Father's Name _____ Phone# _____

3. Other _____Relation_____ Phone# _____

4. Other _____Relation_____ Phone# _____

_____ _____

Parent's Signature Date Physician's Signature Date