

WAYLAND PUBLIC SCHOOLS

MEDICATION ORDER
FOR TREATMENT OF ANAPHYLAXIS USING EPINEPHRINE AND/OR
BENADRYL

(Must be completed by a licensed prescriber)

Student: _____ DOB: _____ Sex: _____

Address: _____

The above named student has a hypersensitivity to: _____

This student is at risk for an anaphylactic reaction. Epinephrine via Epi-pen should be available for treatment. Benadryl given as ordered.

Administer Epi-pen (0.3mg) _____ Administer Epi-pen Jr. (0.15mg) _____

Benadryl: Dose _____ Route _____ Frequency _____

Symptoms _____

TREATMENT PROTOCOL:

If an exposure occurs or is suspected to have occurred begin treatment immediately:

- () Epinephrine should be administered immediately following exposure regardless of symptoms.
- () Epinephrine should be administered if the student develops symptoms suggesting a generalized reaction as described below:
- shortness of breath, wheezing, any difficulty breathing
 - cough
 - rash, hives
 - itching
 - swelling of lips, tongue, mouth
 - general flushing
 - nausea, vomiting abdominal cramps, diarrhea
 - anxiety
 - other symptoms, specific to this student: _____

Signature of Licensed Prescriber

Date

Print Name

WAYLAND PUBLIC SCHOOLS

PARENT/GUARDIAN PERMISSION ALLOWING THE ADMINISTRATION OF
EPINEPHRINE (EPI-PEN) BY UNLICENSED SCHOOL PERSONNEL IN THE
ABSENCE OF THE SCHOOL NURSE

Student's Name: _____ DOB: _____

Address: _____ Grade: _____

Parent/Guardian Name: _____

Home Phone: _____ Other Phone(s): _____

If Parent/Guardian is unavailable in emergency, contact:

Name: _____

Phone(s): _____

Relationship to student: _____

My son/daughter has the following allergy(s) which may require treatment with epinephrine (Epi-pen), according to my child's physician: _____

CONSENT FOR TREATMENT

I give permission to allow the administration of epinephrine by auto-injection (Epi-pen) by the school nurse or, in the absence of the school nurse, by an unlicensed member of the school staff who has been trained and delegated by the school nurse to my son/daughter, in the event of an emergency. I also allow the school nurse to share with appropriate school personnel information relative to this medication administration plan.

Signature of Parent/Guardian

Date

