Regional School District No. 16
Beacon Falls/Prospect Connecticut

Authorization for Epinephrine/Benadryl Administration by School Personnel or Self-Administration

Connecticut State Law requires a written order from an authorized prescriber (*MD, DDS, OD, DO, PA, APRN*) and parent/legal guardian/eligible student (18 years old or emancipated minor) authorization for both prescription and non-prescription medications. All medications shall be delivered to the school by the parent, guardian, eligible student or other responsible adult. The medication must be stored in the original labeled container as dispensed from the pharmacy.

Name of Student: ____ DOB: ______________________ Grade: ________

Known Allergies: ____

If student ingests or thinks he/she has ingested the above named food or has been stung by above named insect***:*** _______________

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Please **note** desired order(s) by number : **Circle desired epinephrine injector dosage**:

____________ Observe patient for symptoms of anaphylaxis*****

____________ Administer Benadryl ______ tsp. Swish and swallow

____________ Administer epinephrine ***before*** symptoms occur - **EpiPen/____________ 0.15 mg. 0.3 mg**

____________ Administer epinephrine ***if*** symptoms occur - **EpiPen/ ____________ 0.15 mg. 0.3 mg**

____________ Administer ____

9-1-1 will be called for anyone with anaphylactic symptoms or EpiPen administration.

***Symptoms of Anaphylaxis may include: Chest tightness, cough, shortness of breath, wheezing, tightness in throat, difficulty swallowing, hoarseness, swelling of lips, tongue or throat, itching mouth or skin, hives or swelling, stomach cramps, vomiting or diarrhea, dizziness or fainting.

Side Effects and Management: ____

Special Instructions: ____

Student is capable of self-administration of EpiPen: ☐ Yes ☐ No (If "*yes*", prescriber training is required.)

Student has been trained in self-administration of this medication in prescriber's office: ☐ Yes ☐ No

Dates of Administration: From: __________ To: _____________

Signature: ______________________________________ **(Physician / Authorized Prescriber) Date:** _____________

Address: ____ Phone: ____________________________

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Parent / Legal Guardian or Eligible Student Authorization

I hereby give permission for qualified personnel to administer/my child to self-administer/the medication above as ordered by his or her authorized prescriber. I understand that if my child is authorized for self-administration any misuse of this medication will result in disciplinary consequences following Regional School District No.16 Board of Education policy and procedure. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.

I give permission for the release and exchange of information between the school nurse and authorized prescriber necessary to ensure the safe administration of such medication.

Signature of Parent/ Legal Guardian/Eligible Student: ____

Date: ______________ Home Phone: ______________________________ Cell Phone: ______________________________

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School Nurse Authorization

Self-administration of medication may be authorized by the prescriber and parent/legal guardian/eligible student and approved by the school nurse in accordance with Regional School District No.16 Board of Education policy/procedure.

School Nurse approval for Self-Administration: { Yes { No: ____

RN Signature: ____________________________________ Date: ____