TOWN OF FAIRFIELD HEALTH PROGRAM
MEDICATION AUTHORIZATION FOR STUDENT WITH SEVERE ALLERGIC REACTION (FOOD, INSECT, LATEX, ENVIRONMENTAL, OTHER)

Name of Student_____ Date of Birth_____

Specific Allergen_____

Please prescribe two auto-injectors for child to have in school if repeat dose is ordered.

A. Epipen Administration (CHOOSE EITHER #1 or #2)

1. **Administer epinephrine immediately** if child knowingly and/or suspects he/she was exposed to the allergen.
   a. Check one: □ Epinephrine 0.3mg IM or SC Epipen Auto-Injector □ Epinephrine 0.15mg IM or SC Epipen Jr. Auto-Injector

   b. Side-effect/plan for management _____

2. **Administer epinephrine if symptoms of anaphylaxis occur.**
   a. Check one: □ Epinephrine 0.3mg IM or SC Epipen Auto-Injector □ Epinephrine 0.15mg IM or SC Epipen Jr. Auto-Injector

   b. Side-effects/plan for management _____

____Repeat x 1 in 10 minutes as needed for symptoms of allergic reaction.

CALL 911 WHENEVER EPINEPHRINE IS ADMINISTERED.

B. Please complete if an Antihistamine is part of the treatment plan for this student.

1. Drug name (**Brand and Generic**) _____
2. Dose _____
3. Route _____
4. Frequency _____
5. Administer (check one)
   ____ immediately following administration of epinephrine (see above).
   ____ at the time of actual exposure or suspected exposure to allergen in the absence of symptoms. Continue to observe for symptoms of anaphylaxis.
   ____ for non-threatening allergic reaction i.e., rash. Continue to observe for symptoms of anaphylaxis.

Side-effects/plan for management _____

Students may self-administer medications(s)___Epipen ____Antihistamine.

Self-administration means that the student will carry and administer his/her medication(s) without assistance.

Duration of Order(s): from _____ to _____(date)

_____ M.D./D.O./D.D.S./A.P.R.N./P.A./O.D.
Signature Date

_____
Address Telephone Fax