

CARROLL COUNTY SCHOOL DISTRICT

Primary Care Provider Authorization: EpiPen (Side One)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ School Year: \_\_\_\_\_

Allergy to: \_\_\_\_\_

Asthma:  Yes  No

Signs of an allergic reaction include:

Systems:	Symptoms:
Mouth	itching and swelling of the lips, tongue, or mouth
Throat *	itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Stomach	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart *	"thread" pulse, "passing out"

**\*The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!**

EpiPen should be:  kept with child  kept in classroom with teacher  kept in front office

Emergency action for an allergic reaction:

1. Administer emergency medication\*

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Route: \_\_\_\_\_

2. Call EMS (9-911)

3. Call Parent/ guardian or emergency contacts immediately:

\_\_\_\_\_  
Emergency Contact

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Relationship

4. Call Primary Care Provider \_\_\_\_\_

Telephone No. \_\_\_\_\_

**\*\*Do not hesitate to administer medication or call for emergency assistance (EMS)**

\_\_\_\_\_  
Printed Name of MD, ARNP, or PA

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature of MD, ARNP, or PA

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Date

**\*Note to parent/guardian: Signing this form shall release the \_\_\_\_\_ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Date

**Primary Care Provider Authorization: Epipen (Side Two)**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ School Year: \_\_\_\_\_

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**Primary Care Provider's Statement of Need**

As primary care provider of the above-name student, I do hereby acknowledge the necessity of specific emergency health procedures of this patient in the event he/she experiences the following health concern during the school day: (Identify health concern/diagnosis).

\_\_\_\_\_

This patient's condition is such of a serious nature that there would not be sufficient time to remove him/her from school premises or to await the arrival of medical help. Therefore, prompt treatment should be given by trained school personnel who have been instructed in the use of: (Specify emergency procedure and/or device required).

\_\_\_\_\_

Printed Name of MD, ARNP, or PA

\_\_\_\_\_

Address

\_\_\_\_\_

Signature of MD, ARNP, or PA

\_\_\_\_\_

Telephone No.

\_\_\_\_\_

Date

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**Parent/Legal Guardian's Authorization and Consent**

I am fully aware and have been informed by the above named primary care provider that my child's condition is of such a serious nature that, if it occurs, there would not be sufficient time to remove him/her from the school premises or to await the arrival of medical help. I hereby give my authorization and consent to trained school personnel to give prompt treatment, as specified above, to my child.

\*Note to parent/guardian: Signing this form shall release \_\_\_\_\_ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give my permission for the above information to be verified with the above health care provider.

\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_

Telephone No.

\_\_\_\_\_

Date

\_\_\_\_\_

Emergency Contact

\_\_\_\_\_

Telephone No.

\_\_\_\_\_

Relationship

**Please complete both sides of this form**