Emergency Alert Plan for Self-Administered Epinephrine

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<th><strong>Student Name:</strong></th>
<th><strong>School:</strong></th>
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**PRESCRIBING PHYSICIAN:**
This student may have a severe allergic reaction to ____________________________________________________

*Thus, it is necessary for him/her to carry an Epinephrine Injector with them during the school day, during activities, and in transit to and from school.*

The student knows how to use the injectable □ Yes □ No
The student has permission and self-administer Epinephrine Injection □ Yes □ No

*With this permission the student agrees NEVER to share their Epinephrine Injector with another person and to seek help IMMEDIATELY from health services personnel or another adult in the event of exposure to a known allergen (regardless of whether or not epinephrine was administrated).*

Symptoms exhibited are:

- □ Shortness of breath: □ Generalized hives
- □ Tightening of throat /airway □ Extreme anxiety
- □ Swelling of face and neck □ Loss of consciousness
- □ Rapid heart rate □ Other ___________________________

The emergency response to be taken by the school staff should include:

- □ Student use Epinephrine*, assisted as needed □ Call 911
- □ Notify parent □ Other ___________________________

*In the event a student requires an Epinephrine injection-emergency services and the parent will be notified.*

**NOTE:** IT IS RECOMMENDED THAT A SECOND INJECTOR BE RETAINED IN THE SCHOOL CLINIC AS A BACKUP IN THE EVENT THAT THE STUDENT DOES NOT HAVE THEIRS AT THE TIME OF THE EMERGENCY

Medication prescribed:

**Physician Signature:**

**Date:**

**PARENT:** I am in agreement with this plan of care and I give permission for the school to follow this. I understand that the principal may rescind this privilege if my child fails to handle the medication safely and appropriately. In the event that epinephrine needs to be administered, I understand that the Emergency Medical System will be called, and my child will be transported to the nearest available hospital for continued medical support. I will notify the school of any changes in my child’s medication or medical condition

Parent/Guardian Signature:  

**Date:**

**HEALTH SERVICES PERSONNEL:** Documentation of this agreement is on file in the clinic

Health Services Personnel Signature:  

**Date:**

**STUDENT SIGNATURE:** Required if self-carry

Student Signature:  

**Date**