Lorenzo ISD
School Nurse
Telephone: (806) 634-5593, ext. 252
Fax: (806) 634-8419

Parent / Physician Request for Administration of

Emergency Anaphylaxis Medication

Student Name:_____ DOB:_____

School Year:_____ Grade:_____ Teacher:_____

ALLERGEN for which medication is given:_____

***For Minor Allergic Reaction:**

1. If symptoms are:_____
   give _____.
2. Notify parent.
3. If condition does not improve within 10 minutes, follow steps for major allergic reaction.

***For Major Allergic Reaction:**

1. If symptoms are: _____
   give EpiPen 0.3 mg Twinject 0.3 mg
   EpiPen 0.15 mg Twinject 0.15 mg
   (Circle correct product & dosage)
2. Call 911 and request advanced life support for possible anaphylactic reaction.
3. Notify parent/guardian.
4. Repeat Epinephrine (if available) after _____ minutes if symptoms don't improve and EMS hasn't arrived.

***Physician Authorization For Student to Carry & Self-Administer Emergency Anaphylaxis Medication**
(Epinephrine Auto Injector (EpiPen/Twinject)

- It is my professional opinion that this student **SHOULD** be allowed to carry & self-administer Epinephrine Auto-Injector (EpiPen/Twinject) while on school property or at school related events.
- It is my professional opinion that this student **SHOULD NOT** be allowed to carry & self-administer Epinephrine Auto-Injector (EpiPen/Twinject) while on school property or at school related events.

Printed name of physician: _____ Date: _____

Physician's signature: _____

Physician's phone number: _____ Fax: _____

*Parent Authorization: I request that oral medication and Epinephrine Auto-Injector (EpiPen/Twinject), that I have provided, be administered to my child according to the signed protocol from my physician. I hereby give my permission for the school nurse to consult with the prescribing physician regarding the above orders.
Parent/Guardin Signature: _____ Date: _____
Emergency phone numbers: _____