

Grapevine-Colleyville ISD

School Health Services

Epi-Pen Authorization

_____ needs to carry a prescription Epi-Pen with him/her.

The above named student is allergic to: _____.

The above named student has been instructed in the proper use of the Epi-pen and fully understands how to administer this medication.

I have completed an allergy action plan for this student to have on file in the school clinic. (see back of this form)

Physician's Signature/Stamp

Date

I have been instructed in the proper use of my prescription Epi-Pen and fully understand how to administer this medication. I will not allow another student to use my Epi-pen under any circumstances. I also understand that should another student use my Epi-pen, the privilege of carrying it with me may be revoked. I understand that the school nurse will be notified immediately if I should require the use of my Epi-Pen, so that emergency medical care can be obtained.

Student Signature

Date

I hereby request that the above named student, over whom I legal control, be allowed to carry his/her Epi-Pen on the GCISD campus(es), and be responsible for its use as needed. I understand that the parent/guardian accepts the legal responsibility should the Epi-Pen be lost, given or taken by a person other than the student for whom it was prescribed. If this should happen, the privilege of carry the Epi-Pen may be revoked. I understand that GCISD has no legal responsibility when the above named student administers his/her own medication. I understand that the campus nurse will be notified immediately if the Epi-Pen is administered, and emergency medical services will be obtained.

Parent/Guardian Signature

Date

Student: _____ DOB: _____

Allergy: _____

Step 1: Treatment

Symptoms	Medication Administration (completed by physician)	
If a food allergen has been ingested but no symptoms	___ Epinephrine	___ Antihistamine
Mouth – Itching, tingling, or swelling of lips, tongue, mouth	___ Epinephrine	___ Antihistamine
Skin – Hives, itchy rash, swelling of the face or extremities	___ Epinephrine	___ Antihistamine
Gut – Nausea, abdominal cramps, vomiting, diarrhea	___ Epinephrine	___ Antihistamine
Throat * – Tightening of throat, hoarseness, hacking cough	___ Epinephrine	___ Antihistamine
Lung *- Shortness of breath, repetitive coughing, wheezing	___ Epinephrine	___ Antihistamine
Heart *- Thready pulse, low blood pressure, fainting, pale, blueness	___ Epinephrine	___ Antihistamine
Other * - _____	___ Epinephrine	___ Antihistamine
If reaction is progressing (several of the above areas affected, give	___ Epinephrine	___ Antihistamine

* Potentially life threatening, the severity of symptoms can quickly change.

DOSAGE:


Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.



- Hold black tip near outer thigh (always apply to thigh).



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions



- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.



SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.



Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

Allergy plan information adapted with permission from The Food Allergy & Anaphylaxis Network.

