

LAKE WASHINGTON SCHOOL DISTRICT NO. 414

HEALTH CARE PROVIDER'S ORDER FOR EPINEPHRINE ADMINISTRATION

Student _____ School _____ Birth date _____

The above named student has a serious allergy that could cause a life-threatening reaction requiring the administration of epinephrine with an "EpiPen".

*Identified Allergen _____

Drug to be administered _____

To be given IM _____

Dosage _____

Follow-up care CALL 911. _____

Indicate if student will carry EpiPen on his/her person. Yes ___ No ___

A district R.N. may not be available to administer this EpiPen or to assess the progression of symptoms. The EpiPen will be given by a trained, designated staff member. If the student is exposed to the allergen identified above, the EpiPen will be administered. 911 will be called.

APPROVAL OF PARENT OR GUARDIAN

I request my student be given injectable epinephrine as indicated by the above health care provider's order because of his/her life-threatening allergy.

I understand there may not be a district R.N. present in the building to administer the EpiPen or to assess the progression of symptoms. I understand the EpiPen will be given by a trained school secretary or other trained designated staff member.

***If your student is exposed to the allergen identified above, the EpiPen will be administered. 911 will be called.**

- This form must be submitted each new school year.
- It is the responsibility of parents/guardians to replace expired EpiPens.

Parent's Signature _____ Date _____

Health Care Providers' Name _____ Telephone _____

Health Care Provider's Signature _____ Date _____