Emergency Care for the Management of a Student with a Diagnosis of Anaphylaxis

Release and Indemnification Agreement for Epinephrine Auto-Injector

MONTGOMERY COUNTY PUBLIC SCHOOLS
MONTGOMERY COUNTY HEALTH AND HUMAN SERVICES
Rockville, Maryland 20850

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Montgomery County Public Schools (MCPS) and Montgomery County Department of Health and Human Services (DHHS) personnel to administer an epinephrine auto-injector as directed by the authorized prescriber (Part II, below). I agree to release, indemnify, and hold harmless MCPS and DHHS and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided MCPS and DHHS staff are following the authorized prescriber's orders as written in Part II. I am aware that the injection may be administered by a trained, unlicensed staff member. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

I understand that the rescue squad (911) will always be called when an epinephrine auto-injector is administered, whether or not the student manifests any symptoms of anaphylaxis.

Student Name: Last _____ First _____ MI ____

Date of Birth ____/____/_____ School Name _____

Signature, Parent/Guardian _____ Phone ____-____-_____ Date ____/____/_____

PART II: TO BE COMPLETED BY THE AUTHORIZED PRESCRIBER

In accordance with Maryland State Regulations, the epinephrine auto-injector may be administered by unlicensed staff (DHHS School Health Room Technician or MCPS employee) that are trained by the School Community Health Nurse (SCHN). Unlicensed staff are **not** allowed to wait for the appearance and observe for the development of symptoms for students with an authorized prescriber's order to administer the epinephrine auto-injector.

1. **Name of medication:** epinephrine auto-injector
   NOTE: *Epinephrine auto-injector will not be accepted for the management of asthma.*
2. **Diagnosis:** Anaphylaxis/Severe allergic reaction to: _____
   _____
3. **Dosage of medication:** Check (✔) one: ❑ epinephrine auto-injector 0.15 mg. ❑ epinephrine auto-injector 0.3 mg.
4. Repeat dose in 10 minutes if rescue squad has not arrived.* ❑ Yes ❑ No
   *NOTE: *For repeat dose, a second epinephrine auto-injector must be ordered and brought to school.*
5. **Authorized Prescriber Order:** Times to be given: Check (✔) all that apply:
   ❑ If insect stings (bees, wasps, hornets, yellow jackets)
   ❑ Ingestion of (specify): _____
   ❑ If other known or unknown allergen(s) (explain): _____
   _____
6. **Route of administration for epinephrine auto-injector:** Intramuscularly (IM) into anterolateral aspect of the thigh.
7. **Side effects:** Palpitations, rapid heart rate, sweating, nausea and vomiting: _____

THIS MEDICATION AUTHORIZATION IS EFFECTIVE ____/____/_____ TO ____/____/_____

Authorized Prescriber _____ ____-____-_____ _____ ____/____/_____
Name—Print or Type | Phone Number | ***Original Signature, Authorized Prescriber*** | Date

SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION: AUTHORIZATION/APPROVAL

Self-carry/self-administration of **emergency** medication **must** be authorized by the prescriber and be approved by the school nurse according to the state medication policy.

Prescriber's authorization for self-carry/self-administration of emergency medication

Signature, Authorized Prescriber _____ Date ____/____/_____

School Nurse (RN) approval for self-carry/self-administration of emergency medication

Signature, School Nurse _____ Date ____/____/_____

PART III: TO BE COMPLETED BY THE PRINCIPAL OR SCHOOL NURSE

❑ Parts I and II are complete, including signatures. It is acceptable if all items in Part II are written on the authorized prescriber's stationery/prescription blank.

❑ Medication properly labeled by a pharmacist. **Epinephrine auto-injectors** received: ❑ 1 injector ❑ 2 injectors

Reviewed by: Signature, Principal/School Nurse _____ Date ____/____/_____

Place Child's Picture Here

Management of Severe Allergic Reactions & Anaphylaxis

HEALTH LINK LLC

Student's Name: _____ **Date of Birth:** _____

Teacher's Name: _____ **Room #:** _____

ALLERGY TO: _____

_____

Asthmatic? (Y/N) _____ (Yes=Higher Risk for Severe Reaction)

STEP 1: TREATMENT

Symptoms	Give This Medication	
	Epinephrine	Antihistamine
If a food allergen is ingested or suspected bee sting, but *no symptoms*		
Mouth: itching, tingling, or swelling of lips, tongue mouth		
Skin: hives, itchy rash, swelling of the face or extremities		
Gut: nausea, abdominal cramps, vomiting, diarrhea		
Throat *: Tightening of throat, hoarseness, hacking cough		
Lung*: Shortness of breath, repetitive coughing, wheezing		
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness		
Other:		
If reaction is progression (several of the above areas affected):		

*Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly:

EpiPen® or generic _____ Epipen JR® or generic _____ Auvi-Q _____

Antihistamine: give _____

Other: give _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad). State that an allergic reaction has been treated and additional epinephrine made be needed.

_____ **Doctor's Name**

_____ **Doctor's Phone Number**

_____ **Parent's Name**

_____ **Parent's Phone Number**

_____ **Emergency Contact 1 Name/Relationship**

_____ **Emergency Contact 1 Phone Number**

EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

_____ **Parent Guardian's Signature/Date**

_____ **Doctor's Signature/Date**