GARLAND INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
Epinephrine Auto-Injector Orders

Students Name: _____ _____
Last First

DOB:mm/dd/yy _____ Grade: _____ ID#: _____

School Year: _____ History of Asthma: Yes:☐ No:☐

ALLERGEN for which medication is given: _____

FOR MINOR ALLERGIC REACTION:

1. If only symptoms are: _____

give by mouth: (***Circle correct medication and strength***) **Cetirizine 5mg/5mL OR 10 mg tabs/capsules**
Diphenhydramine 12.5 mg/5mL OR 12.5 mg tabs OR 25 mg tabs/capsules
Other _____

2. Dosage_____
3. Frequency_____
4. Notify parent.
5. If condition does not improve within 10 minutes, follow steps for major allergic reaction.

FOR MAJOR ALLERGIC REACTION:

1. **If symptoms are**: (circle all appropriate symptoms)

severe hives	facial swelling	throat swelling	cough	wheezing
cramping	nausea/vomiting	hoarseness	dizziness	slurred speech
shortness of breath	difficulty swallowing	sudden quietness	confusion	weakness
lethargy	fainting			

other _____

give: (*Circle correct product and dosage*)

Epinephrine Auto-Injector 0.15 mg

Epinephrine Auto-Injector 0.3 mg

Route: Intramuscular

2. Call 911 and request advanced life support for possible anaphylactic reaction.
3. Notify parent.
4. Repeat epinephrine after _____ minutes if symptoms not improved and EMS not arrived.

Printed name of physician: _____

Physician's signature: _____

Physician's phone number: _____ Fax: _____

Date: _____

For more detailed information about medicines taken during the school day, refer to the Student Handbook or Board Policy FFAC.

I request that oral medication and Epinephrine Auto-Injector 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 Signature: _____ Date: _____

Emergency phone numbers: _____

For OFFICE use only: ☐Med entered in EMR ☐Scanned and uploaded ☐Updated Health Condition ☐Update/create IHP