Hawkins County Schools
Health Services

SELF POSSESSION OF INHALER/EPI-PEN BY A STUDENT

Student's Name_____ Date of Birth _____

School_____ Grade_____ Teacher_____

Authorization to self-possess medication is required from a health care provider. The student's parent/guardian must provide the school with completed physician orders:

- **Permission For Medication** (For possession of an inhaler)
- **Health Care Provider: Emergency Administration of Epinephrine** (For possession of an Epi-pen).

Medication _____

The medication will be located:

Student's locker _____ Student's backpack/purse _____ Other_____

I understand that the Hawkins County School System shall not be held responsible or liable for the administration of the above listed medication. The parent/guardian releases the school district and its employees and agents from liability for any injury that may result from the student's self possession and self-administration of medication. It is the responsibility of the parent/guardian to make sure the child carries the medication on a daily basis as well as on field trips and other off campus activities. It is further understood that my child has received the appropriate training and agrees to follow the guidelines for administration and carrying on person the medication. The school may suspend or revoke the student's possession and self-administration privileges if the student misuses or makes the medication available for usage by another person. If a student uses the medication in a manner other than prescribed, the student may be subject to disciplinary action per board policy.

Parent/Guardian Signature_____ Date_____

Home Phone_____ Work Phone _____ Cell Phone _____

Provider to Complete

Allergy Action Plan

Student's Name _____ D.O.B. _____ Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

Place Child's Picture Here

◆STEP 1: TREATMENT◆

Symptoms:

- If exposed to an allergen, but no symptoms:
- Mouth — Itching, tingling or swelling of lips, tongue, mouth
- Skin — Hives, itchy rash, swelling or face or extremities
- Gut — Nausea, abdominal cramps, vomiting, diarrhea
- Throat† — Tightening of throat, hoarseness, hacking cough
- Lung † — Shortness of breath, repetitive coughing, wheezing
- Heart† — Thready pulse, low blood pressure, fainting, pale, blueness
- Other † _____
- If reaction is progressing (several of the above areas affected), give

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

Give Checked Medication **:

(To be determined by physician authorizing treatment)

☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give: _____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS◆

1. Call 911 (or Rescue Squad: _____) State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ at _____
3. Emergency contacts

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

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

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

(Required)

Hawkins County Schools
Health Service Department
(423)272-7629 FAX: (423)272-~~3469~~ 3556

REQUEST FOR EMERGENCY ADMINISTRATION OF EPINEPHRINE
Health Care Provider

Student Name _____ Date of Birth _____

School _____ Teacher _____ Grade _____

Diagnosis: _____

Food or other substance to which the student is allergic: _____

History of allergies and anaphylactic reaction: _____

Name of medication: _____

Dosage and frequency of medication: _____

Length of time medication is required: Entire School Year _____ Specified Time _____

Signs and symptoms of a reaction: _____

Emergency treatment procedures in the event of a reaction: **Please complete Allergy Action Plan (AAP).**

Additional comments: _____

Assessment of student's competency for Self-Possession and Self-Administration of prescription medication:

Please provide a list of substitute meals that may be offered by school food service personnel:

Health Care Provider Information:

Name _____ Phone _____

Address _____ Fax _____

Health Care Provider Signature _____ Date _____

Pursuant to HIPAA regulations, 45 C.F.R. §164.506, I may disclose protected health information regarding this student's treatment activities to be implemented by the school nurse program.