Southington Public Schools
Southington, Connecticut

Authorization for Epinephrine/Benadryl Administration by School Personnel or Self-Administration

Connecticut State Law requires a written order from an authorized prescriber (MD, DDS, OD, DO, PA, APRN or for interscholastic and intramural athletic events only - DP.) and parent/legal guardian/eligible student (18 years old or emancipated minor) authorization for both prescription and non-prescription medications.

All medications shall be delivered to the school by the parent, guardian, eligible student, or other responsible adult. The medication must be stored in the original labeled container as dispensed from the pharmacy or in unopened over-the-counter packaging. No more than a three-month supply of medication may be left at school.

- Parents/guardians should note the expiration date listed on the packaging before supply is dropped off at school.
- Parents/guardians are responsible for replenishing medication supply prior to the expiration date on the container.

Name of Student: _____ DOB: _____ Grade: _____

Known Allergies: _____

If student ingests or thinks he/she has ingested the above-named food or has been stung by above named insect*:* _____

_____

Please note desired order(s) by number: **Circle desired epinephrine auto-injector dosage:**

_____ Observe patient for symptoms of anaphylaxis*******

_____ Administer _____ tsp Benadryl (Diphenhydramine)
Swish and swallow

_____ Administer epinephrine ***before*** symptoms occur - EpiPen/_____ **0.15 mg. 0.3 mg**

_____ Administer epinephrine ***if*** symptoms occur - EpiPen/_____ **0.15mg. 0.3 mg**

Administer _____

9-1-1 will be called for anyone with anaphylactic symptoms or Epinephrine administration.

***Symptoms of Anaphylaxis may include - Chest tightness, cough, shortness of breath, wheezing, tightness in throat, difficulty swallowing, hoarseness, swelling of lips, tongue or throat, itching mouth or skin, hives or swelling, stomach cramps, vomiting or diarrhea, dizziness, or fainting. ***

Side Effects and Management: _____

Special Instructions: _____

Student is capable of self-administration of Epinephrine: ϒ Yes ϒ No (If Yes, prescriber training required.)

Student has been trained in self-administration of this medication in prescriber's office: ϒ Yes ϒ No

Medication Expiration Date: Epinephrine - / / | Benadryl (diphenhydramine): / /

THIS AUTHORIZATION IS IN EFFECT FOR THE 2023/2024 SCHOOL YEAR: The SY is 8/1 through 7/31

Signature: _____ **(Physician / Authorized Prescriber) Date: _____**

Address: _____ Phone: _____

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Parent / Legal Guardian or Eligible Student Authorization

I hereby give my permission for qualified school personnel to administer to my child the medication ordered above by his or her authorized prescriber (MD, DDS, OD, DO, PA, APRN or for interscholastic and intramural athletic events only- DP.) Any misuse of this medication will result in disciplinary consequences following the Southington Board of Education policy and procedure. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school whichever comes first. I understand that I must verify the expiration date prior to bringing this medication to school and will update this medication appropriately.

I give permission for the release and exchange of information between the school nurse and authorized prescriber necessary to ensure the safe administration of such medication.

Signature of Parent/ Legal Guardian/Eligible Student: _____

Date: _____ Home Phone: _____ Cell Phone: _____

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School Nurse Review of Authorization

Self-administration of medication may be authorized by the prescriber and parent/legal guardian/eligible student and reviewed by the school nurse in accordance with Southington Board of Education policy/procedure.

School Nurse review for Self-Administration: RN Signature: _____ Date: _____