Redondo Beach Unified School District
Special Education Department
1401 Inglewood Avenue, Redondo Beach, CA 90278
Tel. 310-798-8683 Fax. 310-798-8689

EPI PEN ADMINISTRATION and CARE PLAN

School Year: _____ **School:** _____ **Phone:** _____ **FAX:** _____

Student: _____ **DOB:** _____ **Grade/Room:** ____/____

SEVERE ALLERGENS _____

MILD ALLERGENS _____

Has Epi Pen ever been used? NO ☐ YES ☐ AGE: _____

Place photo here

MEDICATION ORDERS

Name of Medication	Dosage Prescribed	Indication / Schedule
ANTIHISTAMINE _____		
INJECTABLE EPINEPHRINE	_____ Epi Pen (.3mg) _____ Epi Pen JR (.15mg) _____ _____	

Special Instructions: _____

MILD REACTION: hives, itching, sneezing, swelling of the face or extremities or if the allergen has been ingested but no symptoms

What to do:

- Administer **Antihistamine** if ordered.
- Call Parent to take home for further observation / Monitor for progression of signs to severe reaction

SEVERE REACTION: DIFFICULTY BREATHING OR SWALLOWING severe symptoms may include: itching, tingling or swelling of the lips, tongue, or throat, nausea, abdominal cramps, vomiting, diarrhea, tightening of throat, hoarseness, coughing, wheezing, nasal flaring, shortness of breath

What to do:

- SUMMON HELP, ADMINISTER **EPI PEN**
- **CALL 911** Parent, Principal, District Nurse
- ONE PERSON STAY WITH STUDENT

Teacher will notify the Health Office two weeks prior to field trips or off campus activities/sporting events for detailed instruction on medication administration.

PARENT STATEMENT:

☐ I hereby request that a school employee store and administer the medication(s) named above per the physician's order

☐ My child (grade 9 and above or under special circumstances agreed upon with district nurse) may carry and is trained to self administer the above medication without adult supervision. I understand and accept that no direct monitoring will be conducted by the school staff. I understand that it is strongly encouraged to have back up medication stored in the school health office.

I agree to provide the medication(s) named above and replacement medication(s) in container(s) labeled by the pharmacy and a change of label if dosage is changed; a new authorization for new medication(s) or changes in the dosage of the medications listed. I understand that it is the Parents' responsibility to immediately notify the school if the child's health status changes, or when a change in physician or medication occurs. I give my consent for the district nurse to communicate with the physician and to counsel with school personnel regarding my child.

These orders expire at the end of the school year and must be renewed at the beginning of each school year.

Parent Name: _____ Home Phone: _____ Work/Cell: _____

Emergency Contact: _____ Home Phone: _____ Work/Cell: _____

_____
Parent Signature **Date**

_____
Physician Signature **Date**

Office Address/Phone Stamp Required

Redondo Beach Unified School District
Special Education Department
1401 Inglewood Avenue, Redondo Beach, CA 90278
Tel. 310-798-8683 Fax. 310-798-8689

EPI PEN ADMINISTRATION and CARE PLAN

USE OF EPI-PEN

1. DETERMINE IF STUDENT HAS SYMPTOMS OF ANAPHYLAXIS
   (When in doubt, treat as an Anaphylactic reaction)

Hives	Flushing
Dizziness	Tingling
Headache	Throbbing heart beat
Nausea	Throbbing in ears
Agitation	Breathing difficulty

2. ADMINISTER EPI-PEN AS FOLLOWS:

   a) Pull off the BLUE Safety Release Cap
   b) Swing and firmly push orange tip against outer thigh so it "clicks"
   c) Hold in place on thigh for 10 seconds

3. CALL PARAMEDICS (911)

4. If an insect sting:
   - Remove stinger with edge of tongue depressor, credit card or fingernail. (Do **NOT** push, pinch or squeeze or further imbed the stinger into the skin as this may cause more venom to be injected.)
   - Apply cold compress and baking soda to affected site.

5. Make student comfortable; keep quiet; give nothing by mouth.

6. Notify parent and school nurse.

7. Remain with student until Paramedics/Nurse arrives.