# Seguin Independent School District
## HEALTH SERVICES

## Self-Administration of Epi-Pen Treatment Plan

Student: _____ DOB: _____ ID#: _____

Date:_____ Teacher:_____ School:_____ Grade: _____

The above student has been instructed by his/her physician in the proper use of the prescribed Epi-Pen. The student will be permitted to keep this medication on his/her possession, as the parent and doctor consider him/her responsible. The student has been instructed and understands the purpose and appropriate method and frequency of the use of the Epi-Pen.

### SIGNS/SYMPTOMS OF AN ALLERGIC REACTION INCLUDE:

**MOUTH** : Itching and swelling of the lips, tongue or mouth
**THROAT** : Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
**SKIN** : Hives, itchy rash, and /or swelling about the face or extremities
**G.I.** : Nausea, abdominal cramps, vomiting and /or diarrhea
**LUNG** : Shortness of breath, repetitive coughing and/or wheezing
**HEART** : "Thready" pulse, "passing out", signs of shock

### TO BE COMPLETED BY PHYSICIAN ONLY

I have instructed the above student in the proper way to use his/her medication. It is my professional opinion that he/she should be allowed to carry and self-administer his/her medication while on school property or at related activities / events.

Medication(s) and purpose: _____

Prescribed dosage of medication: _____

Time of which frequency of circumstances under which the medication may be self-administered:_____

_____

Special instructions / comments: _____

_____

_____ _____ _____
Physician's Signature Physician's Printed Name Date

**➔ EMS TO BE ACTIVATED WHEN ADMINISTERED ←**

**PARENT AGREEMENT:**
I, the undersigned, am giving permission for my child to carry and self-administer his/her own Epi-Pen as ordered by his/her physician while on school property or school related functions. I also absolve the school of any responsibility in safeguarding my child's Epi Pen**. I understand that upon administration of the Epi Pen, EMS will be activated.**

_____ _____ _____ _____
Parent / Guardian Signature Phone / Cell # Work # Date

_____ _____ _____ _____
Alternative Emergency Contact Phone / Cell # Work # Date

**STUDENT AGREEMENT:**
I agree to abide by my physician's instructions and understand the guidelines set by the school.

_____ _____
Student's Signature Date

This form is to be kept on file by the school nurse.

*Revised 06-01-15*