

**ALLERGY TO:** \_\_\_\_\_

Student Name	School Year
Birthdate	Grade/Teacher
Parent Name	Phone #
Physician Name	Phone #

DOES STUDENT REACT BY CONTACT  YES  NO      DOES STUDENT HAVE ASTHMA  YES  NO

**CAUTION!! -- YELLOW ZONE**

Antihistamine	Medication Name	Dose	Route	Frequency

**DO NOT LEAVE STUDENT  
UNATTENDED!!**



Give above medication for the following symptoms:

- if food allergen ingested (or suspected ingestion) but no symptoms
- Mouth itching or tingling or numbness
- Skin Hives, itchy rash
- Nausea, abdominal cramps

*The severity of symptoms can quickly change and progress to a life-threatening situation*

**DANGER- LIFE THREATENING!! RED ZONE**

Epinephrine	Dose	Route	Frequency

May repeat dose one time in 10-15 minutes if no improvement and 911 has not arrived

**DO NOT LEAVE STUDENT  
UNATTENDED!!**



Give above medication for the following symptoms:

- if food allergen ingested (or suspected ingestion) but no symptoms
- Swelling of the lips, face, or extremities
- Swelling of the tongue or mouth
- Vomiting, diarrhea, and abdominal cramping
- Throat tightening, hoarseness, hacking cough
- Shortness of breath, repetitive coughing, wheezing
- Thready pulse, low blood pressure, fainting, pale, blueness
- If more than one body system affected
- Other \_\_\_\_\_

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- I hereby give permission to MTSD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician with any concerns regarding medication administration. I agree to hold the Mequon-Thiensville School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
  - I allow the named physician (office) to send by electronic transmission this form to the Mequon-Thiensville School District for the purpose of continuing health care at school.
  - I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.
  - **ONLY STUDENTS IN GRADES 6-12 WILL BE ALLOWED TO CARRY AND SELF ADMINISTER EPINEPHRINE WITH PHYSICIAN APPROVAL**
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Parent Signature

Date

LICENSED MEDICAL PROVIDER USE ONLY:

Please check the appropriate box and sign below:

- This student possesses the knowledge and skills necessary to carry and self-administer their epinephrine auto injector during the school day and on school sponsored activities.
- This student DOES NOT possess the knowledge and skills necessary to carry and self-administer their epinephrine auto injector during the school day or school sponsored activities.

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Physician Signature

Date

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District Nurse Signature

Date

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**District Nurse**

**Jess Jost**

Phone # 262-238-5630

Email: [jjost@mtsd.k12.wi.us](mailto:jjost@mtsd.k12.wi.us)

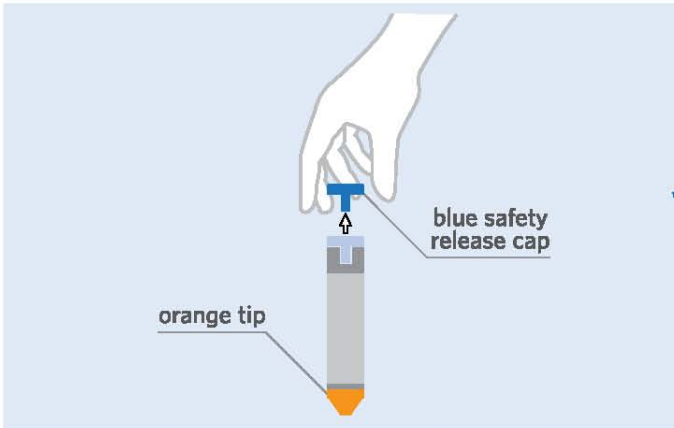
**FAX NUMBERS**

Wilson 262-238-4662 Lake  
Shore 262-238-7650

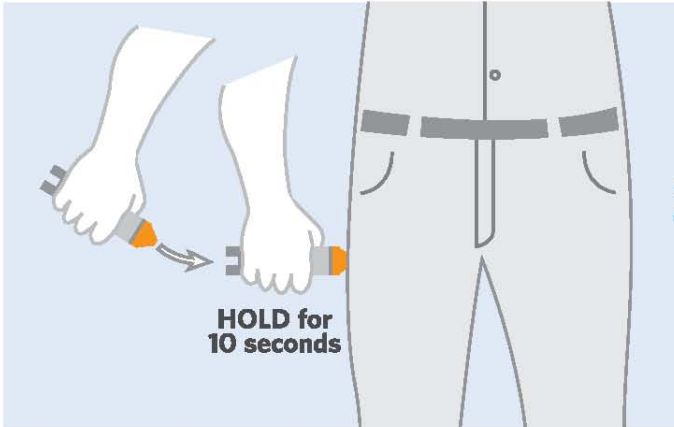
Oriole Lane 262-238-4250  
Steffen 262-238-4740

Donges Bay 262-238-7970  
Homestead 262-238-5633

**EPIPEN<sup>®</sup>**  
(Epinephrine) Auto-Injectors 0.3/0.15mg



**1** Pull off the blue safety release cap.



**2** Swing and firmly push the orange tip against the outer thigh so it 'clicks.' HOLD on thigh for approximately 10 seconds to deliver the drug.

**Please note:** As soon as you release pressure from the thigh, the protective cover will extend.

Each EpiPen Auto-Injector contains a single dose of a medicine called epinephrine, which you inject into your outer thigh. DO NOT INJECT INTRAVENOUSLY. DO NOT INJECT INTO YOUR BUTTOCK, as this may not be effective for a severe allergic reaction. In case of accidental injection, please seek immediate medical treatment.

**Call 911**

**3** Seek immediate emergency medical attention and be sure to take the EpiPen Auto-Injector with you to the emergency room.

**To view an instructional video demonstrating how to use an EpiPen Auto-Injector, please visit [epipen.com](http://epipen.com).**