



Parent's/Guardian's and Physician's Medication Authorization For Emergency Medication - EPIPEN - For Management of Acute Allergic Reaction

THIS IS A LIFE THREATENING EVENT

FOR COMPLETION BY PARENT(S)/GUARDIAN(S)

Full Name of Student: \_\_\_\_\_ School Year \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade \_\_\_\_\_

- I understand that I must supply the school with the necessary equipment/supplies.
I hereby authorize the medication described below to be administered as directed by my child's physician.
I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
911 will be called immediately.

- 1. Is your child capable of self-administering the EpiPen, if needed?
2. Do you want instructions in EpiPen administration to be reviewed with your child?
3. Does your child need to carry the EpiPen with him or her during the school day?

Signature of Parent/Guardian

Date

FOR COMPLETION BY PHYSICIAN
ANAKIT WILL NOT BE ACCEPTED

1. Name of medication: EPIPEN (EPINEPHRINE AUTO INJECTOR)

School personnel will be taught by a registered nurse to administer the epipen. These individuals are non-medical school staff. Medical orders must be clear and explicit as to when the epipen is to be given. These personnel will not make medical judgments or observe for medical symptoms.

2. Reason for medication: Management of acute allergic reactions : (Check one)

- a. Stinging insect
b. Ingestion of \_\_\_\_\_ (specify)

3. Medication is to be given: (Check one)

- a. Immediately after insect sting or
b. Immediately after ingestion of \_\_\_\_\_ (specify)

4. Route of administration: Autoinjection into anterolateral aspect of the thigh

5. Dosage of medication: (Check one) Epipen 0.15 mg. Epipen 0.3 mg.

6. Side effects \_\_\_\_\_

7. 911 WILL BE CALLED IMMEDIATELY.

Physician's Signature
(Original signature/NO stamps)

Date

Physician's Printed Name

Physician's Address

Physician's Telephone Number

Physician's Address

This medication authorization is only valid for the current school year.

Reviewed by Health Services/Health Department R.N. \_\_\_\_\_

Date \_\_\_\_\_