Reviewed by: _____ Date: _____

Lake Washington School District #414 Health Services

EPINEPHRINE MEDICATION ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

This section to be completed by HEALTH CARE PROVIDER

AUTHORIZATION FOR SCHOOL YEAR _____ (e.g. 2025-2026)

ANAPHYLACTIC ALLERGEN(S):	
Medication: EPINEPHRINE	**Possible side effects**: fast/irregular heartbeat, sweating, shaking, paleness, headache, anxiety, restlessness and/or nausea/vomiting ☐ Other: _____
Route/Strength/Dose:	Intramuscular: ☐ 0.3mg/0.3mL ☐ 0.15mg/0.3 mL ☐ 0.15mg/0.15 mL ☐ ___/___mg/mL Intranasal: ☐ 1mg/0.1mL ☐ 2mg/0.1mL
Indications for administration:	☐ Exposure or suspected exposure to an allergen or signs of anaphylaxis ☐ Other: _____
Indications for second dose:	
If a second dose of epinephrine is to be given, time between doses: ☐ 5 min. ☐ 10 min. ☐ 15 min. ☐ Other:_____	
Provide antihistamine following epinephrine administration? (Additional authorization required) ☐ Yes ☐ No	
Follow up care: CALL 911	
If approved by School Nurse, can this student self-carry and self-administer medication?	
This student may self-carry this emergency medication at school	☐ Yes ☐ No
This student is trained and capable of self-administering this emergency medication	☐ Yes ☐ No

I request and authorize that the above-named student be administered epinephrine in accordance with the instructions indicated. There exists a valid health reason which makes administration of the epinephrine advisable during school hours or during such time that the student is under the supervision of school officials. Epinephrine may be administered by non-licensed school personnel.

_____	_____	_____
Health Care Provider Signature	Printed Name	Date
_____	(_____)_____	(_____)_____
Clinic/Office	Phone Number	Fax Number

This section to be completed by PARENT/GUARDIAN

- For epinephrine that the student does not self-administer: I authorize the school to administer epinephrine to my student in accordance with the above order issued by my student's Health Care Provider.
- I understand and acknowledge it is my responsibility to provide an epinephrine auto injector(s) for my student's use and to replace epinephrine auto injector(s) when they are used/expired.
- If my student has permission to self-carry and/or self-administer epinephrine, my student and I understand and accept the responsibility of self-carrying medication at school and acknowledge the school will not track regulatory compliance, expiration date, or amount remaining for self-carried medication. On behalf of my student and as their parent/guardian, I agree to hold harmless and indemnify the Lake Washington School District and its officers, employees, and agents against all claims, demands, damages, costs, judgments, or liabilities arising out of or resulting from or caused by self-administration and/or self-carrying of medication by my student.

I understand and acknowledge that:

- A district RN may not be available to administer epinephrine or to assess the progression of symptoms. **District policy is to administer epinephrine immediately and call 911 if a student has an exposure or a suspected exposure to an allergen or signs of anaphylaxis.** Epinephrine will be given first, followed by an antihistamine (e.g. Benadryl), if one is prescribed and available.
- This order is valid only for the current school year, which includes summer school.

_____	_____	_____	(_____)_____
Signature of Parent/Guardian	Printed Name	Date	Phone Number