

EPINEPHRINE ADMINISTRATION AUTHORIZATION AT SCHOOL

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

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This section to be completed by Health Care Provider

Identified Allergen(s): _____

Medication: EPINEPHRINE Route: INTRAMUSCULAR INJECTION

Strength/Dose: 0.3mg/0.3mL: 0.15mg/0.3mL: _____ / _____ mg/mL:

If second pen available, length of time between doses: _____

If approved by school, can student self-carry and self-administer medication? Yes: No:

Follow up care: Call 911

I authorize administration of epinephrine for suspected exposure to allergen or signs of anaphylaxis. This student has a life-threatening allergy that requires the administration of epinephrine. A district RN may not be available to administer this epinephrine or to assess the progression of symptoms. Epinephrine may be given by a designated staff member trained by the school RN. If epinephrine is administered 911 will always be called.

Health Care Provider Signature

Date

Printed Name

() _____
Phone Number

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This section is to be completed by Parent/Guardian

As the parent/guardian I understand the following:

- I authorize the school to administer epinephrine as indicated above.
- It is my responsibility to replace an expired or used epinephrine auto injector.
- This authorization is valid only for the current school year, which includes summer school.
- If exposure to the allergen identified above is suspected, the epinephrine will be administered and 911 will be called.

Signature Parent/Guardian

Date

Printed Name

() _____
Phone Number