5330 F-1

JACKSON MILTON LOCAL SCHOOL DISTRICT
AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR (EPI-PEN)

Student Name: _____ Date: _____

Address: _____

Name of Medication in Autoinjector: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Prescriber must acknowledge one of the following (please initial)

The student is capable of possessing and using the autoinjector: Yes _____ No _____

The student has been trained on the proper use of the autoinjector: Yes _____ No _____

The autoinjector should be used in the following circumstances: _____

_____

Procedure to follow if student is unable to administer the anaphylaxis medication: _____

_____

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis: _____

_____

Adverse reactions that should be reported to the prescriber: _____

_____

Adverse reactions for unauthorized user: _____

_____

Other special instructions: _____

_____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone (Home) _____
(Work) _____
(Other) _____

Signature: _____ Date: _____

Other Emergency Contact Name: _____ Phone: _____

Parent/Guardian (or student if eighteen (18) or over) must acknowledge one (1) of the following (please initial):

The principal or school nurse has been provided with a backup dose of the student's medication: Yes _____ No _____

Principal or school nurse must acknowledge one of the following (please initial):

I have received a backup dose of the student's medication: Yes _____ No _____