AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR (EPIPEN)

Student Name:_____ Date: _____

Address: _____ DOB:_____ Grade: _____

Name of Medication: _____

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, signatures, and emergency phone numbers are required.

Prescriber Name: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

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

Signature: _____ Phone: (Work): _____

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 (if one has been assigned to the student's building) has been provided with a with a backup dose of the student's medication: Yes _____ No _____

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

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

Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.