100 YEARS
OF EDUCATING YOUNG WOMEN

Physician Authorization for Self-Administration of Epinephrine Injectors

_____ _____
Name of Student Birthdate

_____
Address

_____ _____ (_____) _____
City Zip Code Home Telephone Number

The above named student has _____.
(Name of allergy/medical condition)

I am authorizing the above named student to take the following medication during school hours.

_____
Name of Medication

_____
Dosage Circumstances under which to use

_____
Possible side effects

I certify that _____ has been instructed in the use and
(Name of Student)

self-administration of _____.
(Name of Medicine)

The student understands the need for the epinephrine injector and the necessity to report to school personnel any unusual side effects. The student is capable of using this medication independently.

I may be reached at the following phone number in the event of a reaction to the mediation or an emergency:

_____ _____
Phone Number of Physician Physician's Signature (Date)

_____ _____
Address of Physician Print Name of Physician

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