MIDLAND INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Physician Permission for Student to Carry and Self-Administer EPINEPHRINE INJECTOR

Student Name: ______________________________ DOB: ____________

Homeroom Teacher: ____________________ Grade/Student ID#: ____________

Home #: ____________ Work #: ____________ Cell #: ______________

Emergency Contact: ____

Home #: ____________ Work #: ____________ Cell #: ______________

PRINT Parent /Guardian First and Last Name ________________________

Parent/Guardian Signature ______________________________

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Physician Please Check:

____ It is my professional opinion that ______________________________ should be allowed to Carry and Self-Administer the following medication(s) at school or school related events for management of his/her Severe Allergy. This student has been instructed in the proper way to use his/her medication(s) and understands that these medications cannot be shared with any other person.

Medication Name: ______________________________ Dose: ____________

When to use: ____

How often can mediation be repeated? ________________ At what interval? ________

Additional instructions: ______________________________

Physician Signature: ______________________________

Print Physician's Name: ______________________________

Date: ______________ Office #: ______________ Fax #: ______________

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