APPENDIX A

PENNSAUKEN PUBLIC SCHOOLS
EMERGENCY ADMINISTRATION OF EPINEPHRINE REQUEST
PHYSICIAN ORDERS

Student's Name:_____ DOB:_____ Date:_____

School: _____ Grade: _____

Parent/Guardian: _____ Telephone: (home)_____
(work)_____

To Be Completed by the Physician:

The above named student has a documented history of anaphylaxis or the potential for anaphylaxis caused by an allergy to:
_____.

The above named student is required to have available for emergency administration a pre-filled, single dose auto-injector mechanism containing epinephrine and a back up single dose auto-injector.

Dosage**:**_____

Administer under the following conditions:

Additional instructions/special precautions/possible side effects:

I have instructed the student and the parent/guardian regarding when and under what specific conditions this medication is to be given. The parent is also proficient in the administration of this medication.

_____ _____
Physician's Name (print) Physician's Signature

_____ _____
Telephone Date

To Be Completed by the Parent / Guardian:

I give permission for my child to receive the medication specified above as directed on this form by my child's physician during school hours.

_____ _____
Signature of Parent/Guardian Date