**Medication Authorization Form for the Administration of**
**Emergency Use Epinephrine for Management of Acute Allergic Reaction**

**SECTION 1:** ***For Completion by Parent / Guardian***

Student's Name: _____School: _____ School Year: _____ Grade: ____

1. Do you want the School Nurse / School Health Supervisor to instruct/review instructions on emergency use epinephrine administration with your child? ❑ Yes ❑ No

**SECTION 2:** ***For Completion by Licensed Health Care Provider ONLY***

1. Name of Medication: **EMERGENCY USE EPINEPHRINE**

*Emergency use epinephrine will not be accepted for the management of asthma.*

Volunteer school personnel will be taught how to administer emergency use epinephrine. Volunteer school personnel are nonmedical school staff. Medical orders must be clear and explicit as to when the emergency use epinephrine is to administered. Volunteer school personnel cannot be expected to make medical judgments or observe for medical symptoms to determine when to administer the emergency use epinephrine.

2. Reason for emergency use epinephrine: **Management of acute allergic reactions***: (Check one)*
   - ❑ Stinging insects (bee, wasp, hornet, yellow jacket).
   - ❑ Ingestion of (specify): _____
   - ❑ Other circumstances (specify): _____
3. Emergency use epinephrine is to be given: *(Check one)*
   - ❑ Immediately after an insect sting (bee, wasp, hornet, yellow jacket).
   - ❑ Immediately after ingestion of (specify): _____
   - ❑ Second dose of emergency use epinephrine is to be given _____minutes (specify) after the first dose.
4. Route of administration:
   - ❑ Intramuscularly into anterolateral aspect of the thigh
   - ❑ Intranasal spray
5. Type and Dosage of medication: *(Check one)*
   - ❑ Auto-injectable epinephrine 0.30 mg
   - ❑ Auto-injectable epinephrine Jr. 0.15 mg
   - ❑ Internasal epinephrine 1 mg
   - ❑ Intranasal epinephrine 2 mg
6. Possible side effects from emergency use epinephrine: _____

_____ _____
*Physician's Signature / Date* *Physician's Printed Name*

_____
*Physician's Phone / Fax*

**SELF-CARRY/SELF-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL**

Self-carry/self-administration of **emergency** medication for anaphylactic reactions may be authorized by the prescriber and parent/guardian and must be approved by the school RN/LPN.

Prescriber's authorization for self-carry/self-administration of emergency medication: _____
*Signature/Date*

Parent/Guardian authorization for self-carry/self-administration of emergency medication: _____
*Signature/Date*

School RN/LPN approval for self-carry/self-administration of emergency medication: _____
*Signature/Date*

_____ _____
*Parent's / Guardian Signature/Date* *School Nurse's Signature / Date*

**THIS MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR**