PHYSICIAN AUTHORIZATION
for Self-Administration of Epinephrine Injectors

PARENT PORTION:

_____ _____
Name of Student **Birthdate**

_____
Address

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

TO BE COMPLETED BY PHYSICIAN ONLY:

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

Name of Medication _____

Circumstances to Administer _____

Dosage _____

Possible side effects _____

I certify that the student has been instructed in the use and self-administration of the listed medication(s) and am authorizing the above named student to take the listed medication(s) during school hours.

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

Rev. 4/24