MEDICATIONS AT SCHOOL:
Authorization for Epinephrine Auto-Injector

Please print clearly in ink

PART I: To be completed by PARENT/GUARDIAN

Student: (LAST) (FIRST) ☐M ☐F D.O.B: / /

Allergic to:

Usual specific allergic symptoms:

History of reactions:

PART II: To be completed by PHYSICIAN

Physician Name (PLEASE PRINT):

Telephones: (OFFICE) (FAX)

Prescribed Treatment:

☐ Antihistamine:

Medication: Dose: Route:

☐ Epinephrine Auto-Injector:

Dose: ☐ 0.3 MG ☐ 0.15 MG

Specific Instructions:

Possible Side Effects:

It is in the best interest of the student (my patient) named above to carry an Auto-Injector on his/her person during the school day. I authorize the administration of the medications listed above.

☐ Health Care Provider's authorization for student self-administration if necessary. This student has been adequately trained in correct use of this Epinephrine Auto-Injector.

Physician Signature: (X) Date:

PART III: To be completed by SCHOOL NURSE

☐ This student demonstrates the skill necessary to self administer his/her medication.

School Nurse Signature: (X) Date:

PART IV: To be completed by PARENT/GUARDIAN

Parent/Guardian Name: (LAST) (FIRST)

I understand and agree that:

1. The Auto-Injector will be furnished by me for my child to carry with him/her, and a second one will be provided to the Nurse to keep on campus.
2. Auto-Injector must be labeled by the pharmacy with the name of the student, type of medication, dosage, date prescribed, and date of expiration.
3. I authorize student self-administration if necessary. My child has been trained adequately in the correct use of the Epinephrine Auto-Injector, including when to use, the need to keep the Auto-Injector out of extreme temperatures (hot or cold), and the importance of notifying someone immediately of onset of symptoms.

Brand & Dose Provided: Expiration Date:

Parent/Guardian Signature: (X) Date:

Please send completed form via email to nurses@shelton.org or via fax to 972-408-4139