



AUTHORIZATION FOR THE USE OF EPINEPHRINE AUTOINJECTOR (EPI-PEN)

Name of Student _____ School _____ Class/Grade _____

Address _____ Birthdate _____

Medication Name: _____

Reason for Medication: _____

Dosage: _____

Date administration is to begin: _____

Date administration is to cease: _____

Physician must acknowledge at least one of the following (please initial):

- The student is capable of possessing and using the autoinjector. Yes _____ No _____
- The student has been trained on the proper use of the autoinjector. Yes _____ No _____
- The student is self-carrying the autoinjector* Yes _____ No _____

*** A back-up dose of the medication (epi-pen) is required to be stored in the school clinic.**

The autoinjector should be used in the following circumstances: _____

Procedure to follow if student is unable to administer the anaphylaxis medication: _____

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis: _____

Adverse reactions that should be reported to the physician: _____

Adverse reactions for the unauthorized user: _____

Other special instructions: _____

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Physician and Parent/Guardian names, signatures, and telephone numbers are required.

Physician Signature: _____ Date: _____

Physician Printed Name: _____ Telephone: _____

Parent Signature: _____ Date: _____

Parent Printed Name: _____ Home Telephone: _____

Work/Other Telephone: _____

Parent/Guardian or Student if eighteen (18) or older must acknowledge one of the following (please initial):

- The School Nurse has been provided with a backup dose of the student's medication.

Yes _____ No _____

The School Nurse must acknowledge one of the following (please initial):

- I have received a dose of the student's medication. Yes _____ No _____