This section is to be completed by the student’s Health Care Provider

Please ask your child’s primary health care provider to complete the following:

Identified Allergens: _______________________________________________________________________________

Medication: □ Epinephrine          Route: □ Intramuscular Injection          □ Other: ______________________________

Strength/Dose: □ 0.3mg/0.3ml          □ 0.15mg/0.15ml          □ _____/_____ mg/ml

If second EpiPen is available, length of time between doses: ________________________________________________

If approved by school, can student self-carry and self-administer medication?  □ Yes  □ No

Follow-up Care: □ Call 911          □ Other: ______________________________________________________________________________

I authorize administration of epinephrine for suspected exposure to allergen or signs of anaphylaxis. This student has a life-threatening allergy that requires the administration of epinephrine. A district RN may not be available to administer this epinephrine or to assess the progression of symptoms. Epinephrine may be given by a staff member. If epinephrine is administered, the school will always call 911.

Signature of Health Care Provider: ____________________________  Date: __________________

Printed Name: _________________________________________________________  Phone Number: _______________

This section is to be completed by the student’s Parent/Guardian

As the parent/guardian signing below, I understand that:

□ I authorize the school to administer epinephrine as indicated above.
□ It is my responsibility to replace an expired or used epinephrine auto injector.
□ This authorization is valid only for the current school year.
□ If exposure to the allergen identified above is expected, the epinephrine will be administered and 911 will be called.

Signature of Parent/Guardian: _____________________________________________  Date: __________________

Printed Name: _________________________________________________________  Phone Number: _______________