Student Medical Information:
Epinephrine Administration Authorization Form

Student Name: _____ Date of Birth: _____ Grade: _____

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 avaiblable, 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: _____