

Self-Carry/Administration of Epinephrine Auto-Injector Form

(To be completed at the beginning of each school year and kept on file with the School Nurse)

Student's name: _____ Form: _____ Date: _____

Allergic to: _____

If you choose to have your son self-carry/administer his epinephrine auto-injector, it is required that an additional auto-injector be kept at the Nurse's station.

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To be completed by student's physician:

Physician name: (please print) _____ Office #: _____

Prescribed treatment:

_____ Antihistamine Dosing Instructions: _____

_____ Epinephrine Auto-Injector Dosing Instructions: _____

Possible side effects: _____

It is in the best interest of the above-named student (my patient) to carry an auto-injector on his person during the school day, and I authorize the administration of the medication listed above. This student has been adequately trained in the correct use of this device.

Physician signature: _____ Date: _____

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To be completed by parent/guardian:

Parent/Guardian name: (please print) _____

I understand and agree that:

- The Auto-Injector will be furnished by me for my child to carry with him, and a second one will be provided to the Nurse on campus.
- The Auto-Injector must be labeled by the pharmacy with the name of the student, type of medication, dosage, date prescribed, and date of expiration.
- I authorize student self-administration if necessary. My child has been adequately trained 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 and dose provided: _____ Expiration date: _____

Parent/Guardian signature: _____ Date: _____