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.

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: ______________

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: __________________