Ashwaubenon School District

Authorization for Administration of Epinephrine Medication

School : _____

Student Name: _____

Birthdate: _____/_____/_____ Sex: ☐Female ☐Male

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Physician Name:_____

Phone Number : _____ Fax Number: _____

Emergency Contact Number: _____

Diagnosis: _____

Name of Medication: _____

Dose: _____

Is the child knowledgeable about epinephrine medication? ☐Yes ☐No

Has the child demonstrated the proper technique in administering medication? ☐Yes ☐No

Medicine is administered when needed. Indications: _____

_____

*****ONCE MEDICATION IS ADMINISTERED 911 MUST BE CALLED*****

Possible side effects: _____

Comments: _____

☐ I have instructed _____ in the proper way to use his/her epinephrine medication. It is my professional opinion that her/she should be allowed to carry and use this medication by him/herself.

☐ It is my professional opinion that _____ should **not** be allowed to carry and use this medication by him/herself.

Physician Signature: _____ Date: _____/_____/_____

FOR COMPLETION BY PATIENT/PARENT/GUARDIAN:

Mother's Name: _____

Work Phone Number: _____ Cell Phone Number: _____

Fathers's Name: _____

Work Phone Number: _____ Cell Phone Number: _____

Home Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Is the child authorized to carry and self-administer epinephrine medication? ☐Yes ☐No

As the parent of the above named student, I ask that assistance be provided to my child in taking the medication indicated above at school by authorized staff. If self-medicating is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and my physician. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Signature: _____ Date: _____/_____/_____