<u>AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR</u> (EPI-PEN, AUVI-Q or EPINEPHRINE)

Student Name:	DOB	Date:	
Address:			
Name of Medication in Autoinjector:			
Dosage:			
Date the administration is to begin:			
Date the administration is to cease:			
Prescriber must acknowledge one of the	e following (please initial):		
•	essing and using the autoinjector: n the proper use of the autoinjector:	Yes Yes	
The autoinjector should be used in the f	following circumstances:		
Procedure to follow if student is unable	to administer the anaphylaxis medic	ation:	
Procedure to follow if the medication do	es not produce the expected relief fr	rom the students	anaphylaxis:
Adverse reactions that should be reported	ed to the prescriber:		
Adverse reactions for unauthorized user	r:		
Other special instructions:			

Prescriber and parent/guardian names, signature and emergency phone numbers are required.		
Prescriber name:	Phone:	
Prescriber Signature:	Date:	
Parent/Guardian name:	_ Phone:	
	Phone:	
Parent/Guardian Signature:	Date:	
Other Emergency Contact Name:	_ Phone:	
Parent/Guardian (or student if eighteen (18) years of age or older) must act following (please initial):	knowledge one (1) of the	
The principal or school nurse has been provided with a backup do	se of students medication:	
Yes: No:		
Principal or school nurse must acknowledge one of the following: (please in	nitial)	
I have received a backup dose of student's medication: Yes:	No:	

Copies must be provided to the school nurse and principal.