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### AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR (EPI-PEN)

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_ Building: \_\_\_\_\_

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 following (please initial):

The student is capable of possessing and using the autoinjector:                      Yes                      No

The student has been trained on the proper use of the autoinjector:                      Yes                      No

The autoinjector should be used in the following circumstances:

Procedure to follow if student is unable to administer the anaphylaxis medication:

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis:

Adverse reactions that should be reported to the prescriber:

Adverse reactions for unauthorized user:

Other special instructions:

**Prescriber and parent/guardian names, signature, and emergency phone numbers are required.**

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_

(Work) \_\_\_\_\_

(Other) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Other Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian (or student if eighteen (18) or over) must acknowledge one (1) of the following (please initial):

The principal or school nurse (if one has been assigned to the student's building) has been provided with a backup dose of the student's medication: Yes \_\_\_\_\_ No \_\_\_\_\_

Principal or school nurse must acknowledge one of the following (please initial):

I have received a backup dose of the student's medication: Yes \_\_\_\_\_ No \_\_\_\_\_

**Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.**