MADEIRA CITY SCHOOLS

AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR

Student Name: ______________________________ Date of Birth: ____________

Address: ____

Name of Medication in Auto injector: ______________________________

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 auto injector: Yes __________ No __________

The student has been trained on the proper use of the auto injector: Yes __________ No __________

The auto injector 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 Name: ______________________________ Phone: (home) ____________________

(Work) ____________________

Signature: ______________________________ Date: ____________________

Other Emergency Contact Name: ______________________________ Phone: ____________________

Parent must acknowledge one of the following (please initial):

The principal or nurse has been provided with a backup dose of the student's medication

Yes __________ No __________

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

I have received a backup dose of the student's medication:

Yes __________ No __________