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

Student Name: _____ 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 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.**