AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION
EPINEPHRINE AUTO-INJECTOR

School Year__________

SCHOOL________________________________________ PHONE ______________

ADDRESS____________________________________

Child’s Name_________________________________ Grade________

Allergies______________________________________

________________________________________________________________________

Physician’s Request

Name of prescribed medication ________________________

Reason __________________________________________

Dosage __________________________________________

Side Effects _______________________________________

____ I believe this child is able and responsible to carry and self-administer his/her epinephrine auto-injector.
He/she has permission to do so and has been instructed on how to self-administer.

____ I believe this child is able and responsible to carry and self-administer the medication during field
trips and extra curricular activities. He/she has permission to do so, and has been instructed on how
to self-administer.

Physician’s Signature _______________________________ Date __________

Physician’s Phone _________________________________

Parent Request

I, the parent/guardian of _____________________________________________ request that the employees
of ___________________________________________ School allow my child to follow the guidelines as
set above by my child’s physician. My signature on this document constitutes a complete waiver of liability
claim in any and all respects against the school and all employees unless the school is negligent with regard to
any claim for injury in connection with administration of the prescribed medication.

My wish is for my child to:

____ Carry his/her epinephrine auto-injector and self-administer as per the physician’s order.

____ I request the epinephrine auto-injector be locked up with the understanding that there will not be access to
the medication other than during the academic school day. In other words, my child may not be able to get
to the medication if he/she is having a reaction before or after school hours.

Parent/Guardian Signature ____________________________ Date __________

List all medications currently being taken by this child __________________________________________

________________________________________________________________________