

**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 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_