



# AUTHORIZATION FOR EMERGENCY MEDICATION FOR SEVERE ALLERGIC REACTION

VALID FOR CURRENT SCHOOL YEAR ONLY

Parents must supply two sets of all emergency medications: one set for the classroom and one set for the school clinic.

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

Student's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

List symptoms this student usually exhibits when having an allergic reaction: \_\_\_\_\_

If this student exhibits the above symptoms, or if ingestion of allergen, exposure to allergen, or insect sting is suspected **IMMEDIATELY** administer:

Antihistamine:  Yes  No If yes, list antihistamine and dose: \_\_\_\_\_

Inhaler:  Yes  No If yes, list inhaler and dose: \_\_\_\_\_

Other:  Yes  No If yes, list other medication and dose: \_\_\_\_\_

**Epinephrine injection**  Yes  No If yes,  EpiPen  EpiPen Jr.  Auvi-Q  
**then call 911:**

**If this student appears to have trouble breathing, appears in distress in any way, or if symptoms progress after administering above medications, immediately administer:**

EpiPen  EpiPen Jr.  Auvi-Q **AND CALL 911 IMMEDIATELY**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mom's phone number: \_\_\_\_\_ Dad's phone number: \_\_\_\_\_

## SCHOOL OFFICE USE ONLY

This form is completed and signed by both the physician and parent or guardian.

Medication is in its original container and labeled with the student's name.

School Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_