

**AUTHORIZATION TO ADMINISTER EPI-PEN FOR MANAGEMENT OF
EMERGENCY ACUTE ALLERGIC REACTIONS**

PART I: TO BE COMPLETED BY PARENT/GUARDIAN:

I request that this medication be available in school as prescribed by my student's physician.

My child IS _____ IS NOT _____ capable of self-administering the Epi-Pen if needed.

I DO _____ DO NOT _____ want my child to carry the Epi-Pen during the school day.

I acknowledge that Linton Hall School, staff and agents will not be held responsible for reactions to the medication, an improper dosage in the Epi-pen, etc., and will only be responsible for injuries relating to negligent physical administration of the medication.

Name of Student: _____

Birth Date: _____ Grade _____

Signature: _____

Printed Name _____

Telephone Numbers: _____
(Home) (Work/Emergency)

PART II: TO BE COMPLETED BY PHYSICIAN:

Name of medication: EPI-PEN (EPINEPHRINE AUTO INJECTOR)

ANAKIT WILL NOT BE ACCEPTED IN SCHOOL

EPI-PEN WILL NOT BE USED FOR ROUTINE MANAGEMENT OF ASTHMA

Reason for medication: Management of acute allergic reaction to:

- _____ a. stinging insects (bees, wasps, hornets, yellow jackets)
_____ b. ingestion of _____
_____ c. other _____

Medication is to be given:

- _____ a. immediately after insect sting
_____ b. immediately after ingestion of _____
_____ c. other circumstance _____

Route of administration: intramuscularly into anterolateral aspect of thigh.

Dosage of medication: _____ Epi-Pen 0.15 mg _____ Epi-Pen 0.30 mg

Possible side effects: _____

Physician: _____
(Signature) (Printed name)

Telephone: _____ Date: _____

PART III: TO BE COMPLETED BY ADMINISTRATOR:

Check as appropriate:

- _____ Part I and II above completed with all information.
_____ Medication is properly labeled.
_____ Medication label and dosage match physician order.
_____ I have reviewed the proper use of the Epi-Pen with student and agree/disagree that student should carry it in school.

Administrator signature: _____ Date: _____