

# MEDINA CITY SCHOOLS

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

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Authorization is hereby given for the student named above to:

receive the prescribed medication indicated from the designated school personnel.

keep emergency medication in his/her possession.

self-administer the prescribed medication as permitted by law. **By checking this box, you are acknowledging that the student is capable of possessing and using the autoinjector appropriately and that you have provided the student with training in the proper use of the autoinjector.**

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_

Date the administration is to begin: \_\_\_\_\_

Date the administration is to cease: \_\_\_\_\_

Procedures school personnel should follow in the event the student is unable to administer the anaphylaxis medication: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Procedures school personnel should follow in the event that the anaphylaxis medication does not produce the expected relief from the student's anaphylaxis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Adverse reactions that should be reported to the physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any severe adverse reactions that may occur to another child, for whom the autoinjector is not prescribed, should that student receive a dose of the medication: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other special instructions (including sterile conditions/storage): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician and parent/guardian names, signature, and emergency phone numbers are required.**

Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Parent/guardian name: \_\_\_\_\_ Phone (Home): \_\_\_\_\_

(Work) \_\_\_\_\_ (Other) \_\_\_\_\_

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

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.

07/09