Okeechobee County School Health Services

PHYSICIAN AUTHORIZATION FORM

EPINEPHRINE AUTO-INJECTOR

Student Name_____ **DOB** ___/___/___ **Date** ___/___/___

Part I: To be completed by physician's office
The above named student has had a prior severe allergic reaction and must have the following emergency medication:

[ ] **Epinephrine 0.15 Mg Intramuscularly**
[ ] **Epinephrine 0.3 Mg Intramuscularly**

The student has had allergic reactions to the following: (please be specific)

Food _____ **or Insect** _____

Other _____

Such an allergic reaction may be so severe as to be life-threatening and could occur at school. The Epinephrine Auto-Injector indicated above is an emergency injection of epinephrine that can be immediately available if needed.

CHECK ALL THAT APPLY:

[ ] The student has been properly trained on the use/administration of the epinephrine auto-injector. The student should carry and self-administer the epinephrine (unless unable to)
OR
[ ] Trained school staff should administer the epinephrine

AND the epinephrine should be administered under the following "specific" conditions:

[ ] Immediately post exposure to the allergen
OR
[ ] Administer only if the following reactions occur: (please check **all** that apply)

[ ] Shortness of Breath/Wheezing [ ] Hives/Full Body Rash
[ ] Anxiousness, Cannot Swallow/Verbalize [ ] Generalized Swelling/Edema
[ ] Other _____

Emergency (911) Services will be called if epinephrine is administered so that proper follow-up treatment can be completed.

_____	_____	_____	_____
Physician Signature	Physician Name (Please Print)	Date	Office Number

ATTENTION: Please remember to pick-up student medication(s) by the last day of school, all remaining medications will be disposed of per school policy

For School Nurse/MD Office Use:
Return to _____*at School*_____ *Fax number* _____

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Part II: To be completed by parent/guardian

I hereby give my permission for my child, named in part I, to self administer the Epinephrine Auto Injector during school hours if needed for an allergic reaction. A licensed physician has prescribed this medication and my child has been instructed on its use. I also understand that, if my child must administer the epinephrine, emergency services (911) will be called for follow-up treatment.

If, for any reason, my child is unable to inject himself/herself with the epinephrine, or is unable to make the decision himself/herself as to whether the epinephrine is needed, I give my permission for an adult school staff member who has been trained regarding emergency epinephrine injection to assist my child in the decision and/or administration of the epinephrine.

_____ _____ _____

Parent/Guardian Signature (Firma del Padre/Tutor) Telephone (número de teléfono) Date (Fetcha)

Part III: School Use Only

Reviewed by: _____ _____

School Health Personnel Date

In the space below, list the school personnel who have been trained by a school nurse on the use of the epinephrine auto-injector.

_____

_____

_____

_____

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