



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

**5330 F4**

Student Name: \_\_\_\_\_ Home School: \_\_\_\_\_ Date: \_\_\_\_\_

Student Address: \_\_\_\_\_ Program: \_\_\_\_\_

Name of Medication in Autoinjector: \_\_\_\_\_ Dosage: \_\_\_\_\_

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

**PRESCRIBER MUST ACKNOWLEDGE ONE OF THE FOLLOWING (please initial)**

- The student is capable of possessing and using the autoinjector: Yes \_\_\_\_\_ No \_\_\_\_\_
- The student has been trained on the proper use of the autoinjector: Yes \_\_\_\_\_ No \_\_\_\_\_

The autoinjector should be used in the following circumstances: \_\_\_\_\_

Procedure to follow if student is unable to administer the anaphylaxis medication: \_\_\_\_\_

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis: \_\_\_\_\_

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

Adverse reactions for unauthorized user: \_\_\_\_\_

Other special instructions: \_\_\_\_\_

**PRESCRIBER AND PARENT/GUARDIAN NAMES, SIGNATURES, AND EMERGENCY PHONE NUMBERS ARE REQUIRED.**

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Parent/Guardian Name: \_\_\_\_\_ Home #: \_\_\_\_\_

Work #: \_\_\_\_\_ Other: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Other Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Parent/Guardian (or student if eighteen (18) or over) must acknowledge one of the following (please initial):**

- The Director has been provided with a backup dose of the students medication: Yes \_\_\_\_\_ No \_\_\_\_\_

**Director must acknowledge one of the following (please initial):**

- I have received a backup dose of the student's medication: Yes \_\_\_\_\_ No \_\_\_\_\_