MID-EAST Career and Technology Centers

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_____

Copies to: 1 - Director/Unit Administrator 1 - Parent or Student 1 – File