Emergency Medication Authorization Form
For EPI Pens and Inhalers

Physician's Order

Student's name: ______________________________ Date of birth: ______________
Address: ______________________________ Telephone: ______________

Medication: ____________________ Dosage: ______________ Route: ______________

Specific time/instructions: ______________________________
Reason for this medication and/or intended effect: ______________________________
Possible side effects: ______________________________
Other medications prescribed for this student: ______________________________
Possible drug interactions: ______________________________

Epinephrine Auto-injectors and Asthma Inhalers ONLY
Choice must be initialed by MD

____ Student may self-administer medication. I have instructed the student on the administration of this medication and find that he/she is able to administer this medication independently.

____ Student may carry this medication on his/her person.

Physician's name (please print): ______________________________

Address: ______________________________ Telephone: ______________
Physician's signature: ______________________________ Date: ______________

Parent/Guardian Authorization

The school nurse and/or designee are hereby authorized to administer to the above named student or to allow the self-administration of the lawfully prescribed medication described above. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims against the school and its employees which might arise out of the administration of said medication.

____
Parent/Guardian signature Date

Please note:

- Prescription medication must be in container labeled by a physician or pharmacist.
- Over-the-counter medication must be in the manufacturer's labeled container.