

Grade _____

AUTHORIZATION FOR DISPENSING EPIPENS
(if your child does not have allergies, do not fill out this form

Name of student/camper: _____ DOB: _____

ALLERGIES: _____

Part A. TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission to have the school/camp nurse or any other trained personnel, to administer an EpiPen prescribed by _____ to my child.

I give permission to the school/camp office to share with appropriate school personnel the information relative to the prescribed medication as deemed necessary for my child’s health and safety. **YES** _____ **NO** _____

Parent/Guardian Signature

Date

Phone

Part B. TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER:

I request my patient receive the following medication:

Student/camper: _____ Diagnosis: _____

Name of medication/dosage/route: _____

Start date: _____ Stop date: _____ Time to be administered: _____

Possible side effects or adverse reactions:

The student/camper is both capable and responsible for self-administering this medication. YES NO

Signature of Licensed Prescriber/Physician: _____

Date: _____

Phone: _____