Lehman Catholic HIGH SCHOOL

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

Student Name ..... Date of Birth .....

Address .....
Street City State Zip

Parent / Guardian Name ..... Phone .....

Physician Name ..... Phone .....

PHYSICIAN - PLEASE COMPLETE
The above-named student is under my care and should receive:
Name of medication autoinjector ..... Dose .....
Beginning date of request ..... Expiration date of request .....

The autoinjector should be used in the following circumstances .....
.....
Procedure to follow if the 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 provider .....
.....
Adverse reactions for the unauthorized user .....
.....
Other special instructions .....
.....

Prescriber please acknowledge
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

....
Physician Signature Date

The principal or other designated trained personnel has been provided with a backup dose of the student's medication ..... YES ..... NO

....
Parent / Guardian Signature Date

Parents MJUST send medication to the school in its original container.

Note: The parent/guardian of the child must assume responsibility for informing the principal or a designee (nurse, secretary, teacher, or another responsible trained person) of any change in the child's health or any change in the non-prescribed medication. Any change to the above non-prescribed prescription (dosage or administration) will require the completion of a new form.

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School Official's Signature (Acknowledging Receipt) Date

Revised 06/2021