Permission to Give Epinephrine Medication at School

Child's Name _____ DOB _____

Medication EPI-PEN Jr. (0.15 mg) / Full Strength (0.3 mg) (OR)

Generic Epinephrine Auto-Injector (0.15 mg)/ Full Strength (0.3 mg)

Dosage One unit dose Route Intra-Muscular outer thigh

To be given at the following time(s) as needed for ANAPHYLAXIS

Special Instructions Seek medical care after use

Purpose of medication Treat Anaphylaxis

Side effects that need to be reported _____

Starting date _____ Ending Date None

Health Care Provider Name _____ Phone _____

Fax _____

Health Care Provider Signature _____

I authorize this medication to be given to my child as directed above. I give my consent for the nurse to communicate with the health care provider regarding this medication.

Parent Signature _____ Date _____