Primary Care Provider Authorization: Epipen (Side One)

Student Name: _____Date of Birth:_____

School: _____School Year: _____

Allergy to: _____

Asthma: ☐ Yes ☐ No

Signs of an allergic reaction include:

Systems:	Symptoms:
Mouth	itching and swelling of the lips, tongue, or mouth
Throat*	itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Stomach	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart*	"thread" pulse, "passing out"

***The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!**

EpiPen should be: ☐ kept with child ☐ kept in classroom with teacher ☐ Kept in front office

Emergency action for an allergic reaction:

1. Administer emergency medication*

   Medication: _____

   Dose:_____

   Route: _____

2. Call EMS (9-911)
3. Call Parent/guardian or emergency contacts immediately:

_____ _____ _____

Emergency Contact Telephone No. Relationship

4. Call Primary Care Provider _____

   Telephone No._____

****Do not hesitate to administer medication or call for emergency assistance (EMS)**

_____ _____

Printed Name of MD, ARNP, or PA Address

_____ _____ _____

Signature of MD, ARNP, or PA Telephone No. Date

***Note to parent/guardian: Signing this form shall release the _____ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

Primary Care Provider Authorization: Epipen (Side Two)

Student Name: _____Date of Birth:_____

School: _____School Year: _____

Primary Care Provider's Statement of Need

As primary care provider of the above-name student, I do hereby acknowledge the necessity of specific emergency healthy procedures of this patient in the event he/she experiences the following health concern during the school day: (Identify health concern/diagnosis).

This patient's condition is such of a serious nature that there would not be sufficient time to remove him/her from school premises or to await the arrival of medical help. Therefore, prompt treatment should be given by trained school personnel who have been instructed in the use of: (Specify emergency procedure and/or device required).

_____ _____

Printed Name of MD, ARNP, or PA Address

_____ _____ _____

Signature of MD, ARNP, or PA Telephone No. Date

Parent/Legal Guardian's Authorization and Consent

I am fully aware and have been informed by the above named primary care provider that my child's condition is of such a serious nature that, if it occurs, there would not be sufficient time to remove him/her from the school premises or to await the arrival of medical help. I hereby give my authorization and consent to trained school personnel to give prompt treatment, as specified above, to my child.

*Note to parent/guardian: Signing this form shall release_____ Public School District and staff from liability of any nature that might result from this plan of action. I hereby give my permission for the above information to be verified with the above health care provider.

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

_____ _____ _____

Emergency Contact Telephone No. Relationship

Please complete both sides of this form