



700 Krider's Cemetery Road
Westminster, Maryland 21158
410-848-1050

Physician's Authorization for Emergency Medication – EPIPEN
For Management of Acute Allergic Reaction

TO THE PARENT: I hereby request and authorize Carroll Lutheran School Personnel to administer prescribed medication as directed by the physician (Item II). I have read the procedures outlined on the reverse of this form and assume the responsibilities as required.

I. FOR COMPLETION BY PARENT/GUARDIAN

Name of Student _____ School Year _____

Name of School _____ Grade _____

1. Is your child capable of self-administering the Epipen, if needed? () Yes () No

TO THE PHYSICIAN: Carroll Lutheran School discourages the administration of medication to students in school during the school day. Any necessary medication which can possibly be administered before and after school hours should be so prescribed. School personnel will, however, administer medication to pupils during the school day according to the procedures outlined on the reverse of this form when it is absolutely necessary.

II. FOR COMPLETION BY PHYSICIAN

1. **Name of medication:** EPIPEN (Epinephrine Auto Injection)
2. **Reason for medication:** Management of acute allergic reactions: (Check one)
() a. Stinging insects (bees, wasps, hornets, yellow jackets)
() b. Ingestion of (specify) _____
() c. Other circumstances (specify) _____
3. **Medication to be given:**
() a. Immediately after insect sting (bees, wasps, hornets, yellow jackets)
() b. Immediately after ingestion of (specify) _____
() c. Other circumstances (specify) _____
4. **Route of administration:** Intramuscularly into anterolateral aspect of thigh
5. **Dosage of medication:** (Check one) _____ EPIPEN 0.15 mg. _____ EPIPEN 0.3 mg.
6. **Possible side effects:** _____

THIS MEDICATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR

III. TO BE COMPLETED BY THE PRINCIPAL DESIGNEE

Received from – Name of Parent/Guardian _____ Reviewed and Approved by Name/Title _____

____ Medication Authorization ____ Item I Completed – Prescription label provided ____ Item II Physician's Statement Provided

Signature of Principal/Designee _____ Date _____

Physician's Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

Physician's Printed Name _____ Parent/Guardian Printed Name _____

Physician's Address and Telephone Number _____

Principal's Signature _____ Date _____

