Rock Creek Christian Academy

Physician's Medication Authorization For
EMERGENCY Medication – EPIPEN – For Management of ACUTE Allergic Reaction
THIS IS A LIFE THREATING EVENT

****This Medication authorization is only valid for the current school year****

FOR COMPLETION BY PARENT(S)/GUARDIAN(S)

Full Name of Student_____ Birth Date_____ School year_____

Name of School_____ Grade_____

- I understand that I must supply the school with the necessary equipment/supplies.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- 911 will be called immediately

1. Is your child capable of self-administering the EPIPEN, if needed? [ ] YES [ ] NO
2. Do you want instructions in EPIPEN administration to be reviewed with your child? [ ] YES [ ] NO
3. Does your child need to carry the EPIPEN with him or her during the school day? [ ] YES [ ] NO

_____ _____
Signature of Parent/Guardian Date

FOR COMPLETION BY PHYSICIAN
ANAKIT and TWINJET WILL NOT BE ACCEPTED

1. Name of medication: **EPIPEN (EPINEPHRINE ATUO INJECTOR)**
School personnel will be taught by a registered nurse to administer the epipen. These individuals are non-medical school staff. Medical orders must be clear an explicit as to when the epipen is to be given. These personnel will not make medical judgments or observe for medical symptoms.

2. Reason for medication: [ ] Management of acute allergic reactions [ ] Medication allergy
Check one: _____ Stinging allergy
_____ Ingestion of _____ / _____
(specify) Medication Name

3. Medication is to be given: (CHECK ONE)
A. _____ **Immediately** after insect sting or **B.** _____ **Immediately** after ingestion of _____
(specify)

4. Route of administration: **Auto-injection into anterolateral aspect of the thigh**
5. Dosage of medication: (CHECK ONE) _____EPIPEN 0.15 mg _____ EPIPEN 0.3 mg
6. Side effects _____
7. **911 WILL BE CALLED IMMEDIATELY**

_____ Date_____
Physician's signature (original – NO stamp)

_____ _____
Physician's Printed Name *Physician's Phone Number*

_____
Physician's Address

Reviewed by School Health Services Staff _____
Name/Date