WILMINGTON CITY SCHOOLS

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

Student Name: _____ Date: _____ Building: _____

Address: _____

Name of Medication in Autoinjector: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Prescriber must acknowledge one of the following (please initial):

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

The autoinjector should be used in the following circumstances:

Procedure to follow if 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 prescriber:

Adverse reactions for unauthorized user:

Other special instructions:

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber Name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: (Home) _____

(Work) _____

(Other) _____

Signature: _____ Date: _____

Other Emergency Contact Name: _____ Phone: _____

Parent/Guardian (or student if eighteen (18) or over) must acknowledge one (1) of the following (please initial):

The principal or school nurse (if one has been assigned to the student's building) has been provided with a backup dose of the student's medication: Yes ☐ No ☐

Principal or school nurse must acknowledge one of the following (please initial):

I have received a backup dose of the student's medication: Yes _____ No _____

Copies must be provided to the principal and to the school nurse if one is assigned to the student's building.

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