AUTHORIZATION FORM
SELF-ADMINISTRATION OF PRESCRIBED MEDICATION
AUTO-INJECTABLE EPINEPHRINE

_____ _____
School Date

Re:_____ _____
Students Name Birth date

Dear Physician:

The parents of the above named student have advised us of your request to have their son/daughter carry an auto-injectable Epinephrine on his/her person to use for the relief of a severe allergic reaction.

State law now expressly authorizes students to carry and self-administer an auto-injectable epinephrine if a school district receives certain written statements from physicians and parents. To meet these requirements, the statements below must be completed.

Thank you,

Imperial County Office of Education
School Nurse

_____is under my care. His/her condition warrants immediate
Students Name
inhalation of_____and it is required that this medication be
Medication
carried on his/her person. This student has demonstrated knowledge of correct dosage and usage. Medication is to be used by the above student as follows:

_____ _____ _____
Dosage Time/Frequency Start/stop dates

_____ _____
Physicians Signature Address

_____ _____
Telephone number Date

We the parents of_____ desire the_____to
Student Name School
comply with the orders of the above physician. We release the school district and school personnel from civil liability if the self-administering pupil suffers an adverse reaction as a result of the self-administering medication. We also give permission for the School Nurse or other designated school personnel to consult with the health care provider of the pupil regarding any questions that may arise with regard to the above-described medication.

_____ _____
Parent/Guardian Date