School District of Crandon

EPINEPHRINE ADMINISTRATION FORM

All portions of this medical request form must be completed before medications can be administered by school district personnel.

Student Name: _____ **DOB:** _____
School: _____ **Grade:** _____ **Teacher:** _____

Name of Medication: _____

Dosage: _____ **Time(s) to be given:** _____ ☐ **a.m.** ☐ **p.m.**

Route of Administration: _____

Diagnosis for which medication is to be given: _____

Date of discontinuation: _____

Explain possible reactions: _____

The student has the skill, knowledge, and my authorization to use epinephrine in the following manner:

☐ **Self-carry and self-administer emergency epinephrine in school.**

☐ **I request and authorize that this medication be administered by school personnel. Epinephrine should be kept in the office and readily available in case of emergency.**

Prescribing Physician: _____ **Physician's Phone #:** _____

The School District of Crandon personnel have my permission to administer this medication as indicated above. I agree to hold the School District of Crandon, its employees or agents who are acting on this request, harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately and in writing of any change in the medication order.

I further give permission to the school authorities to contact my child's provider if necessary.

Parent/Guardian signature: _____ Date: _____

Home Phone Number: _____ Work Phone Number: _____

PHYSICIAN AUTHORIZATION

The physician whose signature follows hereby authorizes school personnel to administer medication as prescribed/per the above instructions and agreements. I agree to accept communication regarding the administration procedures. It is understood that the medication may be given by non-licensed personnel.

Physician's Signature: _____ Date: _____