Hillsborough County PUBLIC SCHOOLS
Excellence in Education

STUDENT SUPPORT SERVICES/SCHOOL HEALTH SERVICES
EPINEPHRINE AUTO-INJECTORS PHYSICIAN ORDERS

DATE:		**RETURN TO:**	
TO:		**SCHOOL:**	
ADDRESS:		**ADDRESS:**	
NAME:		**Telephone:**	
DATE OF BIRTH:		**FAX:**	
PARENT/GUARDIAN:			

The student shown above will be attending school in the near future, and we are requiring physician's orders to do the procedures listed below at the school. Please complete the items below and read the statement below. Thank you.

This form is being presented to you to request:

X Physician's orders for medical procedures (*Please specify under response.)*

_____ Medical information: past (_____) current (_____) (An authorization signed by parent is attached)

_____ Exchange information

---

1. What is the child allergic to? _____
2. What are the signs and symptoms of the student's allergic reaction? _____
3. The ***Epinephrine Auto-injector*** will be kept at the school (√ one) ____ In the clinic. ____ With the student.
4. Is the student aware of this allergy and its possible seriousness? Yes _____ No _____
5. Has the student been instructed in the use of the ***Epinephrine Auto-injector***? Yes _____ No _____
6. Is ***Epinephrine Auto-injector*** to be used immediately? Yes No
   If no, at what time after bite, sting, etc. should it be given? _____
   What are the specific signs that signal the need for epinephrine? _____
7. Is it necessary for the student to carry the ***Epinephrine Auto-injector*** on their person? Yes _____ No _____
8. Will student self-administer? Yes _____ No _____
9. Please list any other specific directions to be followed. _____

Epinephrine Auto-injector is to be administered by School Health Services Nursing Staff and other trained school personnel in the event of a severe allergic reaction.

Physician's Signature: _____ **Date:** _____

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

Distribution: Nurse