



**STUDENT 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:

- 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: \_\_\_\_\_