Student Health Services
Telephone: (806) 219-0466
Fax: (806) 766-6680

Parent / Physician Request for Administration of Emergency Anaphylaxis Medication

Student Name: _____ DOB: _____

School Year: _____ Grade: _____ Teacher: _____

ALLERGEN for which medication is given: _____

For Minor Allergic Reaction:

1. If symptoms are: _____
   give _____
   Liquid Diphenhydramine or other medication/dose/route of administration
2. Notify parent.
3. If condition does not improve within 10 minutes, follow steps for major allergic reaction:

FOR MAJOR ALLERGIC REACTION:

1. If symptoms are: _____
   give EpiPen® 0.3 mg Twinject® 0.3 mg
   EpiPen Jr.® 0.15 mg Twinject® 0.15 mg
   (Circle correct product and dosage)
2. Call 911 and request advanced life support for possible anaphylactic reaction.
3. Notify parent/guardian.
4. Repeat epinephrine after _____ minutes if symptoms not improved and EMS not arrived.

Physician Authorization For Student To Carry And Self-Administer Emergency Anaphylaxis Medication
(Epinephrine Auto-Injector (EpiPen®/Twinject®)**:**

☐ It is my professional opinion that this student **SHOULD** be allowed to carry and self-administer Epinephrine Auto-Injector (EpiPen®/Twinject®) while on school property or at school related events.

☐ It is my professional opinion that this student **SHOULD NOT** be allowed to carry and self-administer Epinephrine Auto-Injector (EpiPen®/Twinject®) while on school property or at school related events.

Printed name of physician: _____ Date: _____

Physician's signature: _____

Physician's phone number: _____ Fax: _____

I request that oral medication and Epinephrine Auto-Injector (EpiPen®/Twinject®), that I have provided, be administered to my child according to the signed protocol from my physician. I hereby give my permission for the school nurse to consult with the prescribing physician regarding the above orders.

Parent/Guardian Signature : _____ Date: _____

Emergency phone numbers: _____