Authorization for the

Possession and Use of Epinephrine Autoinjector

Parkway Local Schools

Student Name: ______________________________ School: Parkway Local Schools

Grade: __________

Authorization is hereby given for the above named student to receive the epinephrine autoinjector in the time of need.

Medication Name: ____

Dosage: ____

Date administration is to begin: ______________________, 20__
Date administration is to cease: ______________________, 20__

Note any adverse reactions to watch out for: ________________________________
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Describe the procedure to follow in the event that the medication does not produce the expected relief: ____
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Other specific instructions: ____
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Physician and parent/guardian names, signatures and emergency phone numbers are required.

Physician Name: ______________________________________ Phone: ___________________

Signature: ____ Date: ____________________

Parent/Guardian Signature: _________________________ Phone/Cell: _________________

(Copies must be given to the school nurse, Patty Hipply RN, BSN. Parkway Elementary Fax 419-363-2598.)