

# HOLY CROSS LUTHERAN ACADEMY AND PRESCHOOL

## Student Epi Pen Authorization

Student Name: \_\_\_\_\_ Grade/Class: \_\_\_\_\_

### ***The following information to be completed by parent/legal guardian:***

The above student has a documented  or suspected  allergy to: \_\_\_\_\_  
(Please check one)

Describe allergic reaction & child's complaints: \_\_\_\_\_

Last significant allergic reaction occurred (*describe severity*): \_\_\_\_\_

Asthmatic? Yes\*  No  \*Higher risk for severe reaction

Current daily medications: \_\_\_\_\_

Other information: \_\_\_\_\_

### ***The following information to be completed by the prescribing physician prior to administering medication:***

#### **Medication Authorization – to be completed by physician**

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_  
(valid for 1 calendar school year only)

**Antihistamine:** name of medication \_\_\_\_\_ strength: \_\_\_\_\_

Dosage & frequency: \_\_\_\_\_ route: \_\_\_\_\_

For signs & symptoms: \_\_\_\_\_

**Epinephrine:** thigh injection intramuscularly  EpiPen Jr (0.15mg)  EpiPen Jr (0.3mg)

Twinject (0.15mg)  Twinject (0.3mg)  Do not re-administer 2<sup>nd</sup> dose

May repeat dosage 2<sup>nd</sup> dosage in 10 minutes or \_\_\_\_\_

**Other Medication:** \_\_\_\_\_

For sign & symptoms: \_\_\_\_\_

**If Epinephrine is administered, CALL 911 IMMEDIATELY – this is a MEDICAL EMERGENCY!**

Notify Parent, School Nurse & Administrator

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name and Phone Number: \_\_\_\_\_

Please Print

### The following information to be completed by the parent / legal guardian:

*This information will remain confidential and only shared with school personnel, as needed, for the student's health and education needs. This authorization includes permission for communication between the school office staff / faculty and my child's health care provider, regarding the medications, if necessary. It is my responsibility to provide Holy Cross Lutheran Academy and Preschool with a new medication authorization form if and when these orders change. I am aware that non-medical personnel may administer this medication. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person under the same or similar circumstances. I also understand that HCLA is not responsible for damage, loss of the equipment, or expenses utilized in this treatment and procedure.*

Parent/Legal Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian PRINT name: \_\_\_\_\_ Relationship: \_\_\_\_\_