Baldwin-Woodville Area School District

AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE
(Use separate authorization form for each medication and each student)

BWSD Board Policy 453.4- Exhibit 4

TO BE COMPLETED BY PHYSICIAN/PA/NP

Name of Student: _______________________________Birthdate: ____________Grade: ____________

Diagnosis: ____

Name of Medication: ____

Form: _________________ Specific dose(s) to be given at school: ______________________________

Is the student knowledgeable about his/her Epinephrine medication ☐ Yes ☐ No

Has the student demonstrated the proper technique in administering the medication ☐ Yes ☐ No

Medication is administered as needed ☐ Yes ☐ No - If No, administration time is ________________

If needed, how soon can administration of medication be repeated: ______________________________

The medication can not be repeated more than: ____

Side effects of medication:____

Comments: ____

☐ I have instructed _________________ in the proper way to use his/her Epinephrine medication. It is my professional opinion that he/she be allowed to carry and use this medication by himself/herself.

☐ It is my professional opinion that ___________________ should not carry and use his/her medication by himself/herself.

Printed name of MD/PA/NP: ____

Signature of MD/PA/NP: _______________________________ Date: ______________

Address of MD/PA/NP: ____

Telephone number of MD/PA/NP: ____

Parent Signature and Information

1. Is the student authorized to carry and self administer inhaled medication? ☐ Yes ☐ No
2. If No, was selected in #1, I ask that assistance be provided to this student in taking the medicine indicated above by authorized BWSD staff.
3. If self administering, it is requested that this student be permitted to self-medicate as authorized by myself and the physician.
4. Authorization is granted to release appropriate information to BWSD staff.

Parent/Guardian signature:____ Date:_________________

Print Name:____ Phone:___________________