DIOCESE OF MANCHESTER
REQUEST FOR APPROVAL
TO USE AND POSSESS EPINEPHRINE AUTO-INJECTOR

PLEASE PRINT LEGIBLY

PUPIL NAME _____ DATE _____

PUPIL DOB _____ GRADE _____

FOR COMPLETION BY THE PHYSICIAN

A.	**PUPIL'S NAME**		
B.	**LICENSED SUBSCRIBER NAME, ADDRESS, TELEPHONE NUMBER, AND EMERGENCY NUMBER**		
C.	**NAME, ROUTE, AND DOSAGE OF MEDICATION**	**D.**	**FREQUENCY AND TIMING OF MEDICATION ADMINISTRATION**
E.	**DATE OF THE ORDER**		
F.	**DIAGNOSIS AND ANY OTHER MEDICAL CONDITION(S) REQUIRING MEDICATION, IF NOT A VIOLATION OF CONFIDENTIALITY OR IF NOT CONTRARY TO THE REQUEST OF THE PARENT OR GUARDIAN TO KEEP CONFIDENT.**		
G.	**SPECIFIC RECOMMENDATIONS FOR ADMINISTRATION**		
H.	**SIDE EFFECTS, CONTRAINDICATIONS, OR ADVERSE REACTIONS**		
I.	**REQUIRED MEDICATION**		
J.	**ANY SEVERE ADVERSE REACTION THAT MIGHT OCCUR TO ANOTHER PUPIL, TO WHOM THE EPINEPHRINE AUTO-INJECTOR IS NOT PRESCRIBED, SHOULD SUCH A PUPIL RECEIVE A DOSE OF THE MEDICATION.**		

This pupil has the knowledge and skills to safely possess and use an epinephrine auto-injector in a school or camp setting.

_____ _____

PHYSICIAN SIGNATURE **DATE**

FOR COMPLETION BY PARENT/GUARDIAN

My child/ward has been diagnosed with severe, potentially life-threatening allergies. S/He has the knowledge and skills to safely possess and use an epinephrine auto-injector. The treating physician attests to this knowledge and skill. I request that my child/ward be allowed to possess and use an epinephrine auto-injector at school/camp or at any school/camp-sponsored activity, event or program.

My child/ward is aware that s/he must report to the nurse, or if one is not available, to the school principal or camp administrator immediately after using an epinephrine auto-injector.

PARENT/GUARDIAN NAME (PRINT)_____

PARENT/GUARDIAN SIGNATURE _____

STUDENT SIGNATURE _____

DATE _____

FOR SCHOOL/CAMP USE ONLY ---------- RECORD OF AUTO-INJECTIONS

DATE	TIME	REASON	PERSON REPORTED TO	TIME REPORTED