AUTHORIZATION FOR DISPENSING MEDICATION
IN SCHOOL OR CAMP

PARENT/GUARDIAN:

I request that my child _____ receive their epi-pen administration as directed in the form below and prescribed by:

_____.
Physician's Name

_____
Signature of Parent/Guardian

Telephone No. _____ Date:_____

PHYSICIAN:

I request that my patient _____ receive the following medication:

Name of Medication: Epipen ☐ Jr (up to 66 lbs) or ☐ Regular (Over 66 lbs)

Diagnosis: Allergy to_____

Prescribed Dosage: 1 pen injected in lateral or anterior thigh
Time to be taken during school or camp hours: As needed for severe allergic reaction
Expected duration of treatment: Lifetime
Possible side effects and adverse reactions: Very rapid heart rate, nervousness, hand tremors

Other recommendations: Must call 911 immediately; also administer Benadryl and, if asthmatic, administer Albuterol. May repeat in 15 minutes if ambulance has not arrived and still having a severe reaction.

Print Name:_____ **Tel. No:** 617-323-4440

Signature: _____ **Date:**_____