Permission to administer Epinephrine

Location: _____

Child's Information

Full Name: _____

Date of Birth: _____

Medication Information:

Name of medication *(as it appears on the container)* _____

Special Instructions for storage: _____

Dosage: _____

Route *(how to administer)*:_____

Specific time/frequency medication should be administered: _____

Maximum frequency allowed within 24 hours: _____

Purpose of the medication/medical need: _____

Possible side effects: _____

Start date for administration: _____

End date for administration: _____

Prescriber's Information:

Prescribers Name: _____

Prescribers Phone Number: _____

Health Care Provider Stamp/Signature: _____

Date: _____

Parent/Guardian Information and Consent:

Parent/Guardian name: _____

Phone Number: _____

I confirm/consent: (initial)

_____ All information on this form is accurate and true.

_____ This medication was given at least once to my child without adverse effects.

_____ Staff has permission to communicate if necessary with the prescriber.

Signature: _____

Date: _____