



# Van Buren Elementary School

301 South Main Street Van Buren, Ohio 45889  
Phone: (419) 299-3416 Fax: (419) 299-3566



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## AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTO INJECTOR (EPI-PEN)

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Medication in Auto injector: \_\_\_\_\_

Dosage: \_\_\_\_\_

Date the administration is to begin: \_\_\_\_\_

Date the administration is to cease: \_\_\_\_\_

Prescriber must acknowledge one of the following (please initial):

The student is capable of possessing and using the auto injector: Yes \_\_\_\_\_ No \_\_\_\_\_

The student has been trained on the proper use of the auto injector: Yes \_\_\_\_\_ No \_\_\_\_\_

The auto injector should be used in the following circumstances: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Procedure to follow if student is unable to administer the anaphylaxis medication: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Procedure to follow if the medication does not produce the expected relief from the student's

Anaphylaxis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Adverse reactions that should be reported to the prescriber: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Adverse reactions for unauthorized user: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list specific allergies and any other special instructions:

\_\_\_\_\_



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Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Parent/Guardian Name: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_

(Work) \_\_\_\_\_ (Other) \_\_\_\_\_

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

Other Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_