

**PENNSAUKEN PUBLIC SCHOOLS  
EMERGENCY ADMINISTRATION OF EPINEPHRINE REQUEST  
PHYSICIAN ORDERS**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Telephone: (home) \_\_\_\_\_  
(work) \_\_\_\_\_

**To Be Completed by the Physician:**

The above named student has a documented history of anaphylaxis caused by an allergy to:  
\_\_\_\_\_.

The above named student is required to have available for emergency administration a pre-filled, single dose auto-injector mechanism containing epinephrine and a back up single dose auto-injector.

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

Administer under the following conditions:

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

Additional instructions/special precautions/possible side effects:

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

I have instructed the student and the parent/guardian regarding when and under what specific conditions this medication is to be given. The parent is also proficient in the administration of this medication.

\_\_\_\_\_  
Physician's Name (print)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date

**To Be Completed by the Parent / Guardian:**

I give permission for my child to receive the medication specified above as directed on this form by my child's physician during school hours.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date