Dear Physician,

This form is being presented to you to request your orders for medical procedures. The student shown above will be attending school in the near future, and we are requiring your orders to do the procedures listed below at the school. Please complete items 1 to 9, read the statement below, and fax or return orders to the school nurse or clinic.

1. What is the child allergic to? __________________________________________________________

2. What are the signs and symptoms of the student’s allergic reaction? ________________________________

3. The Epinephrine Auto-injector will be kept at the school (✓ one) in the clinic. ___ with the student. ___

4. Is the student aware of this allergy and its possible seriousness? Yes ___ No ___

5. Has the student been instructed in the use of the Epinephrine Auto-injector? Yes ___ No ___

6. Is Epinephrine Auto-injector to be used immediately? Yes ___ No ___

   If no, at what time after bite, sting, etc. should it be given? ________________________________

   What are the specific signs that signal the need for epinephrine? ________________________________

7. Must the student carry the Epinephrine Auto-injector on their person? Yes ___ No ___

8. Will student self-administer? Yes ___ No ___

9. Please list any other specific directions to be followed. ________________________________________________

In the event of a severe allergic reaction, the Epinephrine Auto-injector is to be administered by School Health Services Nursing Staff and other trained school personnel.

Physician’s Signature: ____________________________ Date: ____________________________

Physician’s Printed Name: ________________________ Phone: ____________________________

Distribution: Nurse
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