Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

SCHOOL HEALTH SERVICES
EPINEPHRINE AUTO-INJECTORS PHYSICIAN ORDERS

Student: _____ Student #: _____

Parent/Guardian: _____ Phone: _____

Physician: _____ Phone: _____ Fax: _____

School: _____ Phone: _____ Fax: _____

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
SB 87033 (Rev. 5/17/2018)