***EPI-PEN AUTHORIZATION FORM - DUE AUG 1 - REQUIRES PHYSICIAN SIGNATURE***

**Part I: (to be completed by the PARENT/GUARDIAN)**

I hereby request and authorize Mater Dei School personnel to administer an epinephrine auto injector as directed by the health care provider (Part II, below). I agree to release, indemnify, and hold harmless Mater Dei School and any of their officers, staff members or agents from lawsuit, claim, demand or action against them for administering prescribed medication to this student. It is understood that Mater Dei School staff will follow the health care provider's orders as written in Part II. I am aware that the injection may be administered by a trained, unlicensed staff member. I understand that the rescue squad (911) will always be called when an epinephrine auto injector is administered, whether or not the student manifests any symptoms of anaphylaxis.

Student Name _____ DOB ___ / ___ / ___

Grade/Class: ____

_____ ___ / ___ / ___

PARENT SIGNATURE DATE

**Part II: (to be completed by the HEALTH CARE PROVIDER)**

*In accordance with Maryland State Regulations, the epinephrine auto injector may be administered by unlicensed staff at Mater Dei School that are trained by the Supervising Health Nurse.*

The above named student has had a prior severe allergic reaction and must have the following emergency medication: ☐ ***Epi-pen Jr. 0.15 mg*** ***OR*** ☐ ***Epi-pen 0.3 mg***

**The student has had allergic reactions to the following:**

*(check all that apply and provide explanation if additional details are necessary)*

☐ ***Insect stings (bees, wasps, hornets, yellow jackets)***

☐ ***Ingestion of (specify): _____***

☐ ***Other allergens and/or more information _____***

_____

*Such an allergic reaction may be so severe as to be life-threatening and could occur at school. TheEpinephrine Auto-Injector (Epi-pen) is an emergency injection of epinephrine that can be immediately available if needed.*

**The Epi-pen should be administered under the following "specific" conditions:**

☐ Immediately post exposure to the allergen

OR

☐ Administer only if the following reactions occur: (please check all that apply)

☐ Shortness of Breath/Wheezing ☐ Hives/Rash

☐ Anxiety ☐ Generalized Swelling/Edema

☐ Other _____

_____ ___ / ___ / _____ _____ - _____ - _____

PHYSICIAN NAME DATE PHONE