PHYSICIAN'S WRITTEN ORDERS AND CERTIFICATION FOR CHILDREN REQUIRING ADMINISTRATION OF EPINEPHRINE FOR ANAPHYLAXIS

(To be completed by your child's physician or advanced practice nurse)

STUDENT NAME: _____ DOB _____
SCHOOL: _____ GRADE:____ TEACHER:_____

Allergy Diagnosis requiring administration of epi-pen (please include the date and description of the child's previous allergic or anaphylactic reaction):_____
_____
_____

Signs of child's past allergic reaction have included (please circle)

Systems	**Symptoms**
Mouth	Itching & swelling of the lips, tongue or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	Hives, itchy rash and/or swelling about the face or extremities
GI	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung	Shortness of breath, repetitive coughing and/or wheezing
Heart	"Thready" pulse, "passing out"

Please list any additional medical conditions and/or dietary restrictions:
_____
_____
_____

Administer the following dose of epinephrine:
(Circle one): Epi-pen Jr.
Epi-pen
Other
Indications for use (please be specific):
____ For observed signs of anaphylaxis
____ Upon being stung by an insect
____ After ingestion of _____
____ Other _____

Please check one of the boxes below:
I certify that _____requires the administration of epinephrine for anaphylaxis and does not have the capability for self administration of the medication.

I certify that _____requires the administration of epinephrine for anaphylaxis and has been instructed in the safe use of epinephrine, and is capable of carrying and self administering the auto injector of epinephrine prescribed

_____ _____
Signature of physician or advanced practice nurse Date

_____
Printed name of physician or advanced practice nurse

_____
Street Address

_____ _____
City State Zip Code Phone

_____ _____
Parent/Guardian Signature Date