SMITHFIELD PUBLIC SCHOOLS
EPINEPHRINE/ALLERGY MEDICATION REQUEST FORM

Name of Student: _____ Date: _____

Diagnosis for which medication is given: _____

If medication is to be given, describe indications:

_____

1. Epinephrine Auto-injector and Dosage

_____ 0.15 mg _____ 0.30mg ____

Route: IM Time: PRN

List significant side effects: _____
Other Information: _____

May be self-carried Yes ____ No____
Self-Administered Yes ____ No ____

This Epi pen will be administered by a trained staff person accompanying the child on a field trip or away from school activity..

2. Anti-histamine and Dosage _____

Route: PO Time: PRN

Other Information: _____
_____

May be self-carried Yes ____ No____
Self-Administered Yes ____ No ____

****Medication orders must be renewed prior to the start of each school year.**

Physician Signature _____ Date_____

I understand that special permission is required for the use of medication by students during school hours. I request that my child be given the above medication as prescribed by physician.

Parent Signature _____ Date _____

Revised

6/2017