Northern Highlands Regional High School

Administration of Epinephrine
Physician's Orders

School Year: _____ - _____

(Please Print or Type)

Student's Name:_____
Last *First*

Date of Birth: _____ Grade_____

I have documented symptoms of anaphylaxis for the above named student.

Symptoms include _____

_____

This student requires the administration of epinephrine via a pre-filled single or double dose auto-injector mechanism for anaphylaxis and does not have the capability for self-administration of this medication.

Please arrange for administration of epinephrine by the School Nurse or in the absence of the School Nurse administration by a delegate school employee designated by the school nurse if the parent consents to the administration of the epinephrine by the delegate.

Signature of Physician _____

Name of Physician _____ Phone #_____
Print

Date _____