AQUIA HARBOUR PRESCHOOL

Epi-Pen Authorization

**A copy of this form must be kept in the student file & attached to Epi-Pen in a locked container.*

Part 1: To be completed by Parent/Guardian

Child's Name: _____ DOB: _____

Physician's Name: _____

Physician's Phone #: _____

I authorize the staff of Aquia Harbour Preschool to administer the following medication as directed to the child named above.

Parent/Guardian Signature _____ Date: _____

Part 2: To be completed by Physician

Name of medication: _____

Medication Valid through (state end date): _____

Method of administration: _____

Place to be administered: _____

Relevant side effects and plan for management if any occur: _____

_____

Name of Authorized Prescriber: _____

Physician Signature: _____ Date: _____