MIDLAND INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Physician Permission for Student to Carry and Self-Administer EPINEPHRINE INJECTOR

Student Name: _____ DOB: _____

Homeroom Teacher: _____ Grade/Student ID#: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____

Home #: _____ Work #: _____ Cell #: _____

PRINT Parent /Guardian First and Last Name _____

Parent/Guardian Signature _____

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Physician Please Check:

____ It is my professional opinion that _____ should be allowed to Carry and Self-Administer the following medication(s) at school or school related events for management of his/her Severe Allergy. This student has been instructed in the proper way to use his/her medication(s) and understands that these medications cannot be shared with any other person.

Medication Name: _____ Dose: _____

When to use: _____

How often can mediation be repeated? _____ At what interval? _____

Additional instructions: _____

Physician Signature: _____

Print Physician's Name: _____

Date: _____ Office #: _____ Fax #: _____

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