



Leesburg United Methodist Preschool

**Epi-Pen Authorization Form
2008-2009**

PART I – Parent or Guardian to Complete

Child's Name _____ Date of Birth _____

I hereby authorize Leesburg United Methodist Preschool, LUMP, personnel to administer epinephrine injection as directed by the physician (Part II). I agree to release, indemnify, and hold harmless LUMP and any of their officers, staff members, or agents from lawsuit, claim, expense, demand, or action against them for administering the injection, provided they follow the physician order as written in Part II below. I am aware that the injection may be administered by a specifically trained non-health professional. I have read the procedures accompanying this form and assume responsibility required.

Signature _____ Date _____

PART II – Physician to Complete

Emergency injections are usually administered at LUMP by non-health professionals. These persons are taught to administer the injection. For this reason, only pre-measured doses of epinephrine may be given. It should be noted that these staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.

The following injection will be given immediately after report of exposure to _____
_____ Indicate specific allergen and type of exposure
(e.g., ingestion, skin contact, or inhalation).

Check as appropriate:

Epi-pen

- Give the pre-measured dose by auto injection.
- Repeat dose in 15 minutes if rescue squad has not arrived.
(Two kits will be needed in school.)

Epi-pen Jr.

- Give the pre-measured does of 0.15 mg epinephrine 1:2000 aqueous solution (0.3cc).
- Repeat dose in 15 minutes if rescue squad has not arrived.
(Two kits will be needed in school.)

Check appropriate box:

I believe that this student has received adequate information on how and when to use an Epi-pen.

- The student is to carry an Epi-pen during school hours. The student can use the Epi-pen properly in an emergency.
- The Epi-pen will be kept in the school clinic.

NOTE: Medication expiration date must be clearly indicated.

Print Physician's Name _____ Date _____

Signature _____ Telephone _____

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PART III – Director or Designee to Complete

- Parts I and II above are completed including signatures. (It is acceptable if all items of information in Part II are written on physician stationery or a prescription pad.)
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- Medication is appropriately labeled.

Signature _____ Date _____