## **EpiPen / EpiPen Jr**

### **Student Information**

|  |  |
| --- | --- |
| Student’s Name | MaleFemale  |
| Date of Birth | School | Class |
| Name of Parent/Guardian | Place student’s photo here |
| Phone (Home)  |
| Phone (Work) |
| Phone (Mobile) |
| Name of Alternative Contact |
| Relationship to Student |
| Phone (Home) |
| Phone (Work)  |
| Phone (Mobile)  |
| Name of Doctor / Surgery | Telephone (Surgery) |
| List your child’s allergies | Site of Medical Alert BraceletLeft arm Right arm Neck Other  |
| What are the early warning signs for your child if experiencing an allergic reaction? | When is this allergic reaction like to occur? |
| How do you manage your child’s allergies (EpiPen, tablets, diet?) |
| Does your child give own EpiPen injection? Yes No  |
| Medication Name | Dosage | Frequency | Side effects |
|  |  |  |  |
| Additional information / instructions |
| Permission for school staff to administer EpiPen in an emergency Yes No  |
| Signature of Parent / GuardianDate | Signature of PrincipalDate |
| Signature of School NurseDate | Signature of First Aid OfficerDate |