Appendix B

Hamilton-Wentworth Catholic District School Board

PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FOR ANAPHYLACTIC REACTION

Complete When The School is First Informed of Condition or if the Condition Changes

To be Completed by Attending Physician/ Nurse Practitioner

(Please Print or Type)

Demographic Information

Student's Name: ____________________________________

Birthdate: Month ________________________ Day___________ Year ______________

Ontario Education Number (OEN): ____

Description of Allergy

Foods, products, substances etc. which are to be avoided:

Description of Symptoms of Allergic Reaction

☐ Cardiovascular System (Heart) ____

☐ Gastrointestinal System (Stomach) ____

☐ Respiratory System (Breathing) ____

☐ Skin System ____

☐ Other ____

Medical Certification

This is to certify that (Name) ____ has a potentially life-threatening allergy to ________________________________ and must be given an epinephrine auto-injector in the event of an anaphylactic reaction.

Dosage:

- ☐ Epipen ® Jr. 0.15 mg
- ☐ Epipen ® 0.30 mg

Possible side-effects of medication administration: ____

Additional medications which may be administered after the epinephrine auto-injector include:

____

(Physician/Nurse Practitioner Authorization to be completed only when information is new or has changed)

Physician/ Nurse Practitioner Name: ______________________ *Telephone:* ________________

Physician/ Nurse Practitioner Signature: __________________________________

Date: Month ___________ *Day* _____________ *Year* ________________

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in Main Office)

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