Appendix B

**Hamilton-Wentworth Catholic District School Board**

# PHYSICIAN/NURSE PRACTITIONER 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 _____ has a potentially life-threatening
(name)
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)

*This information is collected, retained, accessed and otherwise used in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c. M-56 and the Personal Health Information Protection Act, 2004, S.O. 204, c. 3, Sched. A.*