

**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.*