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 **Child's** 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.