**San Francisco Unified School District – School Health Programs, SFCSD**

# Epinephrine Auto Injector MEDICATION FORM

親愛的家長/監護人/看顧人：

加州教育法令第 49423 條規定，學生如需在上課日服用醫生處方或非醫生處方藥物，可由學校人員協助，但只在校區收到醫護服務提供者及學生家長/監護人/看顧人的具體書面說明後，方予進行。**請填妥本表格各部分，並 交回校長。**

**Please print legibly in all sections**

| Student Name: Last | First | Middle | Date of Birth (Month/Day/Year) |
|---|---|---|---|
| | | | |

## HEALTH CARE PROVIDER SECTION

| | |
|---|---|
| **Health Condition for which medication is prescribed:**<br>Severe Allergic Reaction to the following: | **Medication:** Please circle<br>Epinephrine Auto-Injector Adrenaclick Auvi-Q<br>EpiPen EpiPen Jr.<br><br>Dose: ☐ 0.15 mg ☐ 0.3 mg |
| **Symptom of Severe Allergic Reaction include:**<br>Mouth: itching, swelling of lips/tongue<br>Throat*: itching, tightness/closure, hoarseness<br>Skin: itching, hives, redness, swelling<br>Gut: vomiting, diarrhea, cramps<br>Lung*: shortness of breath, cough, wheeze<br>Heart*: weak pulse, dizzy, passing out *can be life-threatening | |
| **Medication Route:** Injection to outer thigh | **Time medication to be given at school?** As needed |
| **The medication is to be given:**<br>-If suspicion of exposure to the source of allergy AND at least one symptom<br>-Any life-threatening symptom | **Any precautions that school personnel need to know? Contraindications?** |
| **What are possible side effects of the medication?**<br>Increased heart rate, dizziness, shakiness, paleness, weakness, anxiety, headache | **What should be done after administering Epinephrine?**<br>Call 911 after administering medication and give used auto-injector to paramedics to bring to ER with student |

**Check appropriate boxes below:**

❒ **I authorize this student to self-administer the above medication.**

❒ **I authorize designated school personnel to administer the above medication.**

| Print name, address & phone number of Health Care Provider | Signature of Health Care Provider | Date: |
|---|---|---|
| | | |

## 家長/監護人/看顧人填寫部份

| 家長/監護人/看顧人姓名 | | | 在家所用語言 | 日間電話 ( ) |
|---|---|---|---|---|
| 地址 – 號碼及街名 | 公寓號碼 | 城市 | 郵區編號 | 晚間電話 ( ) |
| 學校 | | | 兒童中心 /小學 /初中 /高中 | 上課時間 |

**請在下面適當空格上劃"√ "**：

❒ 本人允許子女自己服用以上藥物。

❒ 本人允許指定學校人員給本人子女服用以上藥物。

1. 本人同意，三藩市聯合校區及其僱員無須為服藥的後果或服藥方法負任何責任。
2. 三藩市聯合校區及其僱員若因這些安排而需負責，本人將予賠償。
3. 子女服用的藥物如有改變，本人會立即通知校長。
4. 本人明白，本人送到學校的藥物需用藥房原裝藥瓶來裝，藥瓶需有標籤，標籤上需有本人子女姓名及醫護服務提供者的 指示。
5. 本人明白，學年完結時，本表格將自動失效。
6. **爲了本人子女的安全與健康著想，本人同意校方採取適當行動。**

家長/監護人/看顧人簽名________________________日期____________________