

**APPLICATION FOR SCHOOL
EPINEPHRINE AUTO-INJECTOR PROGRAM**

Facility: *(Complete an application for each individual school)*

(Name of School)

(School District)

Physical Address (No PO. Boxes)

(City, State, Zip Code)

Mailing Address (if different from above)

(City, State, Zip Code)

Primary Phone: _____ Alternate Phone: _____

Qualified Supervisor of Health/School Administrator

(Name)

Title

Primary Phone: _____ Alternate Phone: _____

E-mail Address: _____

Epinephrine Auto-Injectors

Type of School: Elementary ☐ Middle School ☐ Jr. High School ☐ High School ☐

Type of Epinephrine Auto-Injector Requested	Quantity Requested
Junior epinephrine auto-injector – for patients 15 to 30 kg (33 – 66 lbs)	
Regular epinephrine auto-injector – for patients greater than or equal to 30 kg (66 lbs)	

School nurse on-site? ☐ YES ☐ NO Number of trained personnel: _____

Signature of Qualified Supervisor of Health/Administrator:

Print Name

Signature

Date

EMS Agency Use Only:

1. Application Received by: _____ Date: _____
2. Application Complete: _____
3. Reviewed by EMS: ____ / ____ / ____ Initials: _____
4. Prescription Issued: # Regular: _____ # Junior: _____ Issue Date: ____ / ____ / ____