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: __ __ / __ __ / __ __**