To be filled out **only if** your child has a severe allergy that may require **immediate** access to an epinephrine auto-injector.

EPIPEN AUTHORIZATION

(Inhaler Authorization on Reverse Side)

Part 1 To be completed by the Parent or Guardian		
Camp: Child's Name		
	Date of Birth	
Physicians Address (elephone (business)) elephone (Emergency)	
I request that my child be assisted in taking the medicine(s) described below at camp by authorized persons or permitted to medicate her/himself as also authorized by me and my physician (see below).		
Date Parent/Guardian Signature () Home phone	Emergency Phone	
Print Name		
To be completed by the PHYSICIAN:		
Diagnosis	Medication(s):	
Date of Order	Form: Route:	
If Medicine is to be given when needed, describe indications:	Dose: Time interval for repeating dosage:	
List significant side effects/contraindications/adverse reactions:	List any severe adverse reactions that may occur to another child, for whom the epinephrine auto-injector is not prescribed, should such an individual receive a dose of the medication.	
I believe that this individual has received adequate information on how and when to use an epipen and that he or she can use it properly		
Please specify if:		
The above named individual is to carry an epipen during their stay at camp. (an additional epipen, to be used as backup must be kept in the health office or other appropriate location.)		
—OR—		
The epipen will be kept in the health office or other appropriate location.		
Other information:		
Date: (Physicians Signature)	_	

To be filled out **only if** your child may require **immediate** access to an inhaler to alleviate asthma symptoms or before exercise to prevent the onset of asthma symptoms. (ie. albuterol/proventil inhalers)

INHALER AUTHORIZATION

(Epipen Authorization on Reverse Side)

Part 1 To be completed by the Parent or Guardian	
Camp:	
	Date of Birth
Physicians Address)
	elephone (business)) elephone (Emergency)
To	elephone (Emergency)
I request that my child be assisted in taking the medicine(s) described below at camp by authorized persons or permitted to medicate her/himself as also authorized by me and my physician (see below).	
Date Parent/Guardian Signature () Home phone	Emergency Phone
-	Emergency Phone
Print Name	
To be completed by the PHYSICIAN: Diagnosis	List Triggers
Date of Order	Medication(s):
If Medicine is to be given when needed, describe indications:	Form:
	Route:
	Dose:
List significant side effects/contraindications/adverse reactions:	Time internal Communities desired
	Time interval for repeating dosage:
I believe that this individual has received adequate information on how and when to use an inhaler and that he or she can use it properly	
Please specify if:	
The above named individual is to carry an inhaler during their stay at camp. (an additional inhaler, to be used as backup must be kept in the health office or other appropriate location.)	
—OR—	
The inhaler will be kept in the health office or other appropriate location.	
Other information:	
Date: (Physicians Signature)	
(Physicians Signature)	