

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**TRAINED/DELEGATED STAFF MEMBERS**

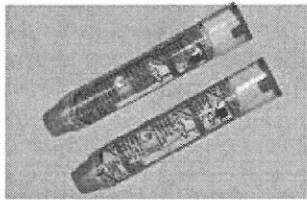
- |          |            |
|----------|------------|
| 1. _____ | Room _____ |
| 2. _____ | Room _____ |
| 3. _____ | Room _____ |
| 4. _____ | Room _____ |
| 5. _____ | Room _____ |

Self-carry contract on file.  Yes  No

Medication located in: \_\_\_\_\_

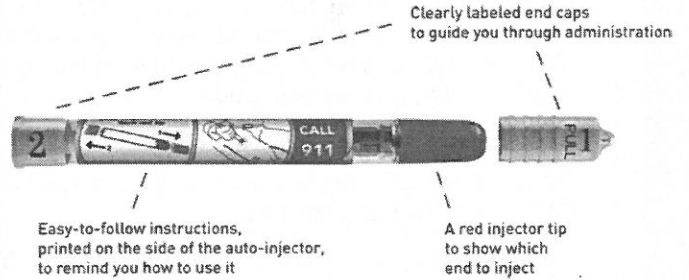
**EpiPen® and EpiPen® Jr.**  
Expiration date: \_\_\_\_\_

- Pull off blue activation cap.



- Hold orange tip near outer thigh (through clothing, if needed)
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

**Adrenallick 0.3 mg. and 0.15 mg**  
Expiration date: \_\_\_\_\_



**Auvi-Q 0.3 mg. and 0.15 mg**  
Expiration date: \_\_\_\_\_

- Pull the Auvi-Q™ from the outer case.
- Pull off Red safety guard.
- Place black end against the middle of the outer thigh (through clothing, if needed), then press firmly, and hold in place for 5 seconds.



**Once epinephrine is used, call 911.  
Student should remain lying down or in a comfortable position.**

Additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL STATEMENT FOR SCHOOL MEAL MODIFICATION**

I certify that the student's food allergy rises to the level of a disability & qualifies for school meal modification.

1. List foods to be omitted: If YES, a separate USDA form must be completed. Ask School Nurse for this form. \_\_\_\_\_

2. Indicate food modification/substitutions: \_\_\_\_\_  
\_\_\_\_\_

Signature by a licensed MD or DO only \_\_\_\_\_ Date \_\_\_\_\_