AUTHORIZATION FOR ADMINISTERING EPIPEN/EPIPEN JR.

SOUTHEAST VENTURA COUNTY YMCA

Date: _____

Dear Doctor:

Your patient, _____, is enrolled/enrolling in our center and we have been requested to administer EpiPen/EpiPen Jr. Please complete this instruction record. This record will remain in the child's file at the YMCA so we may assist with the care and needs of our enrollee and your patient.

Child's Name:_____

Child's Birth Date:_____

PROCEDURES

Please provide in detail the symptoms of severe allergy/anaphylactic shock:

_____
_____
_____
_____

Please specify, in detail, all procedures relating to your patient, including specific indications for administering EpiPen/EpiPen Jr.:

_____
_____
_____
_____

Please provide in detail potential side effects and actions to be taken in the event of side effects:

_____
_____
_____
_____

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Please specify, in detail, proper storage of EpiPen/EpiPen Jr.:

_____
_____
_____
_____

Please specify in detail who is authorized to provide training to YMCA child care staff to administer EpiPen/EpiPen Jr. (first and last name, relation to child):

_____
_____

If there are any other comments, instructions, restrictions, or provisions not listed above, please indicate:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Child's Physician

Name:_____

Address:_____ Telephone No.:_____

Emergency Contact No.:_____

Signature:_____ Date:_____

To Be Filled Out By Parent(s) and/or Guardian(s)

Parent(s) or Guardian(s):

Name: _____

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Address:_____
Telephone No.: _____
Emergency Contact No.: _____

Name: _____
Address: _____
Telephone No.: _____
Emergency Contact No.: _____

Indicate the person(s) who is/are authorized to administer EpiPen/EpiPen Jr. and provide care.
Check all that apply:

__ **YMCA** Personnel
__ Parent(s) or Guardian(s)
__ Child
__ Siblings Name(s): _____
__ Other Name(s): _____

BY SIGNING THIS FORM, I/WE AUTHORIZE THE YMCA TO FOLLOW THE ABOVE INSTRUCTIONS. I/WE AGREE TO UPDATE THIS FORM EVERY TWELVE (12) MONTHS, OR SOONER, IF MY/OUR CHILD'S NEEDS CHANGE.

Signature:_____ Date:_____
[Parent/Guardian]

Signature:_____ Date:_____
[Parent/Guardian]

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I, _____ verify that I am certified to train staff for administering and overseeing the administration of Epipen/EpiPen Jr. per the written approval of _____ (name of child) physician. The following staff have been trained to administer or oversee administration of EpiPen/EpiPen Jr. according to the written instructions of the child's physician on _____ (date).

Training start time: _____. Training end time: _____.

Training included:

1. Recognizing symptoms of severe allergic reaction/anaphylactic shock and take appropriate action.
2. Properly administer or oversee administration of the EpiPen/EpiPen Jr.
3. Calling 9-1-1 and child's parents/guardian immediately after EpiPen/EpiPen Jr. is administered.
4. Recognize possible side effects.
5. Reviewing EpiPen/EpiPen Jr. for expiration.

Name of Staff: _____ Signature: _____

Name of Staff: _____ Signature: _____

Name of Staff: _____ Signature: _____

Name of Staff: _____ Signature: _____

Name of Staff: _____ Signature: _____

Authorized Trainer: _____ Signature: _____

COPY IS TO BE PLACED IN EACH STAFF FILE AT CENTER.