TORRANCE UNIFIED SCHOOL DISTRICT PHYSICIAN'S AUTHORIZATION for MANAGEMENT OF ANAPHYLAXIS AND EPINEPHRINE AUTO-INJECTOR ADMINISTRATION AT SCHOOL

Additional medical orders/special instructions: Possible adverse side effects of epinephrine auto-injector: NOTE: 911 Emergency services will be called and student transported to emergency room is anaphylactic reaction of and is treated in the school setting. There may be circumstances where it is important for the student to have the medication on their person: Yes, student is authorized to carry, and is able to self-administer auto-injectable epinephrine independently (authorized lice health care provider initials: Not Health office is best location, student requires supervision Authorized Health Care Provider' Authorization for Management of Anaphylaxis in the School Setting My signature below provides authorization for the written orders on pages 1 and 2. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may performed by an unilicensed designated school personnel under the training and supervision provided by the school nurse. The authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations be faxed. Office Stamp (required): Authorized Health Care Provider Signature Date Telephone Fax Furnishing number (Nurse Practitioner, Physician Assistant, and Nurse Midwife): Supervising Physician Name: Phone: Address City State Zip Yene: Phone: Address City State Zip Authorized Health Care Provider includes California-licensed physicians and surgeons, dentists, optometrist, podiatrists, nur practitioners, and physician assistants or California-certified nurse midwives. Parent Consent for Authorization and Management of Anaphylaxis in the School Setting I (we) the undersigned, the parent(s)/guardian(s) of the above named student, request that the specialized physical healthcas service, anaphylaxis treatment, be administered to my (our) child by designated school purse in the residuace written consent/authorization for any	Last Name of Student, First Name		Grade	Sex	Date of Birth	
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