



EPINEPHRINE AUTO-INJECTOR OR ASTHMA INHALER FORM

Child's Name: _____

This child **does** use an epinephrine auto-injector or an asthma inhaler. Please complete the following:

Camper has a: Asthma inhaler Epinephrine auto-injector (Epi Pen) Both

Name of Medication:	Recommendation for Administration:
Route of Medication:	
Dosage:	Any special side effects, contraindications, or adverse reactions to be observed:
Time Taken:	
Frequency:	Date of Order:

Your child's physician must complete the following:

I/we certify that the child may possess and use an asthma inhaler or epinephrine auto-injector while at camp and I/we certify that the child has the knowledge and skills to safely possess and use this medication.

Name of **Licensed Prescriber**: _____ Date: _____

Signature: _____

Business Telephone: _____ Emergency Telephone: _____

Name of **Parent/Guardian**: _____ Date: _____

Signature: _____

Business Telephone: _____ Emergency Telephone: _____



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Camper Name: _____

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Route of Medication:	
Dosage:	Any special side effects, contraindications, or adverse reactions to be observed:
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Your child's physician must complete the following:

I/we certify that the child may possess and use an asthma inhaler or epinephrine auto-injector while at camp and I/we certify that the child has the knowledge and skills to safely possess and use this medication.

Name of **Licensed Prescriber**: _____

Date: _____

Signature: _____

Business Telephone: _____

Emergency Telephone: _____

Name of **Parent/Guardian**: _____

Date: _____

Signature: _____

Business Telephone: _____

Emergency Telephone: _____

