Asthma & Allergy Physicians
Est. 1972

Michael Lawrence, M.D.
Ralph Cahaly, M.D.
Mark T. Claus, M.D.
Gloria Iheuwa, FNP-BC
Darlene Madore, CPNP-PC
Carolyn Rooney, FNP-C
*Leslie A. Stefanowicz, FNP-BC_*

SCHOOL MEDICATION FORM FOR EPINEPHRINE

Patient Name: _____
Date of Birth: _____

Address: _____
_____

Patient's Weight_____ Name of Licensed Provider _____

☐ 35 Pearl St. Suite 300 Brockton, MA 02301
☐ 675 Paramount Dr Suite 303 Raynham, MA 02767
☐ 888 Washington St Suite 305 Dedham, MA 02026
☐ 115 Water St Suite 203 Milford, MA 01757

Medication: ◯ Epipen ◯ EpiPen Jr. ◯ Auvi-Q ◯ Neffy

Dosage: ◯ 0.1 auto-injection ◯ 0.15 mg auto-injection ◯ 0.3 mg auto-injection
◯ 1mg nasal inhaler ◯ 2mg nasal inhaler

Frequency: **Use one unit at first sign of reaction involving difficulty swallowing, tongue swelling, hoarseness, lightheadedness, or hypertension**

Special Instructions: **CALL 911**

Route of Administration: ◯ IM Thigh ◯ Intranasally

Patient's Diagnosis: _____

Date of Order: _____ Discontinuation Date: _____

Possible Side Effects: increased heart rate, jitteriness, tremor, headache

Consent for self-administration (provided the school nurse determines it is safe and appropriate)

YES_____ NO_____

_____ _____
Signature of Licensed Provider Date

updated 6/2026