

SCHOOL FORMS REQUEST (please allow up to 2 wks for completion)

Drop-off Date: _____

Patient Name: _____ Date of Birth: _____

Current weight: _____ Date weighed: _____

Last seen: _____ Future appointment: _____

For albuterol/Xopenex: OK for patient to self-carry OK for patient to self-administer

For epinephrine autoinjector: OK for patient to self-carry OK for patient to self-administer

Contact name when form completed: _____

Phone number: _____

After completion: Parent pick-up (We'll call when ready) Mail to home

Send via Portal (*must be signed up*)

Fax to school (*Parent/guardian must sign school form(s) to authorize us to send form(s) to school*)

Fax # _____ School name: _____

MEDICATION(S) REQUEST (please allow up to 2 business days)

Pharmacy Name: _____ Pharmacy Phone Number _____

Epinephrine autoinjectors

Mylan epinephrine autoinjector

Brand name only OK for generic Mylan OK to substitute with other non-Mylan generics

AuviQ (only for commercial insurance & sent by mail-order) Impax epinephrine autoinjector

Other medications

Medication #1 : _____ Dose: _____

Medication #2 : _____ Dose: _____

Medication #3 : _____ Dose: _____

Medication #3 : _____ Dose: _____