Permission to Administer Emergency Epinephrine

Participant's name: _____

Your Licensed Health Care Provider (LHCP) – MD/DO, PA or NP - must complete this form in the event the athlete goes until anaphylactic shock due to an unknown allergy.

Date of birth: _____

Physician's name: _____

Address: _____

Telephone number: _____

As the examining LHCP, I understand that RSR stores an emergency auto-injectable epinephrine and it will be maintained in a secure manner. In the event the auto-injectable epinephrine is used it will be reported to the state Public Health Department where the camp is located.

_____ _____

Signature of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner (Please Circle)

Date

_____

Please Print Name

_____

Please Print Office Address

Phone Number