



**Allergies and Medical Restrictions  
Epipen Authorization and Waiver of Liability**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Does your child have any allergies (e.g., Food, Environmental, Lotions/Creams, etc.)?  
 \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, please list, and indicate type of reaction:  
 (If your child's reaction is severe please supply the center with additional medical advice from your doctor.)

Allergy (please list each separately)	Reaction	Plan for Management
1.	___ Mild ___ Severe Describe:	
2.	___ Mild ___ Severe Describe:	
3.	___ Mild ___ Severe Describe:	
4.	___ Mild ___ Severe Describe:	
5.	___ Mild ___ Severe Describe:	
6.	___ Mild ___ Severe Describe:	

Does your child suffer from Asthma? \_\_\_ Yes \_\_\_ No

If yes, please answer the following

1. Does your child have a Rescue Inhaler and/or Spacer Inhaler \_\_\_ Yes \_\_\_ No
2. Does your child self administer the medication or is assistance needed? \_\_\_\_\_
3. Name of the medication \_\_\_\_\_
4. Dose to be given \_\_\_\_\_

Please include any preventative information and/or symptoms that we need to know to help ensure the safety of your child (please list any medical restrictions here):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- PLEASE SEE Next Page FOR ADDITIONAL INFORMATION -



What actions would you like us to take if we observe what appears to be an allergic reaction?

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**Action for Minor Reaction:**

1. If Symptoms are:

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2. Administer (medication/dose/route):

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3. Then call Parent/Guardian

**Action for Severe Reaction:**

1. If Symptoms are:

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2. Administer (medication/dose/route):

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3. Call 911

4. Then call Parent/Guardian

Does your child require the use of an EpiPen in the event of a severe allergic reaction?

\_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

If yes, do you authorize BY YOUR SIDE-Autism Therapy Services staff to administer or attempt to administer to your child?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, do you authorize BY YOUR SIDE-Autism Therapy Services to allow your child to self administer the lawfully prescribed EpiPen?

\_\_\_\_\_ Yes \_\_\_\_\_ No

(Important Note: In the event that we administer an EpiPen to your child, we will first administer the EpiPen, then call 911, and then call you as quickly as possible)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_