Town of Milton

Summer Recreation Program

Medical Authorization for Epi-Pen or Inhaler Use

The following must be completed by the physician:

Diagnosis for which Epi-Pen and/or inhaler is given: ______________________________

Name of Medication: ______________________________

Form: ______________________ Dose: ______________________

If Epi-Pen and/or inhaler is to be given "WHEN NEEDED" describe indications: ______________

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How soon can medication be repeated? ______________________________

Has child been trained to self-administer? ______________________________

List significant side effects: ______________________________

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Other information: ______________________________

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______________________ ______________________

Physician signature Date

recreation@townofmiltonny.org