Northern Territory Government

DEPARTMENT OF **EDUCATION**

EpiPen / EpiPen Jr
Student information Sheet

Student's Name		Male ☐ Female ☐
Date of Birth	School	Class

Name of Parent/Guardian	*Place student's photo here*
Phone (Home)	
Phone (Work)	
Phone (Mobile)	
Name of Alternative Contact	
Relationship to Student	
Phone (Home)	
Phone (Work)	
Phone (Mobile)	

Name of Doctor / Surgery	Telephone (Surgery)
List your child's allergies	Site of Medical Alert Bracelet Left arm ☐ Right arm ☐ Neck ☐ Other ☐
What are the early warning signs for your child if experiencing an allergic reaction?	When is this allergic reaction like to occur?
How do you manage your child's allergies (EpiPen, tablets, diet?)	
Does your child give own EpiPen injection? Yes ☐ No ☐	

Medication Name	Dosage	Frequency	Side effects

Additional information / instructions	
Permission for school staff to administer EpiPen in an emergency Yes ☐ No ☐	

Signature of Parent / Guardian Date	Signature of Principal Date
Signature of School Nurse Date	Signature of First Aid Officer Date