National Inventors Hall of Fame®

AUTHORIZATION FOR ADMINISTRATION OF SEVERE ALLERGY OR PRESCRIBED MEDICATIONS

I/We wish to enroll your patient, ______________________________ in a National Inventors Hall of Fame program and we are requesting that they provide certain emergency care for the prevention of anaphylaxis if he/she comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain on file at the site of the program and also at National Inventors Hall of Fame home office in North Canton, Ohio. If you need to provide further instructions or clarification, please document them on a separate piece of paper to serve as an addendum to this form.

PART I (TO BE COMPLETED BY A PHYSICIAN) *(Residents of CA, IL, MA, NC, SC, SD & WI may skip this section and complete Part II.)*

______________________________ ______________________________

Patient's Name: Patient's Date of Birth:

Allergies or Prescribed Medication:

Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (anaphylactic shock).

☐ Bee Sting ☐ Other Insect Bites (Identify) ____________________ ☐ Animal Fur (Identify) ____________

☐ Food Allergies:______________________________ ☐ Other Allergies (Identify):____________________

Child will bring: ☐ Inhaler ☐ Diabetes Device ☐ Other Medication _______________

Name of Drug: ______________________ Dosage: ______________________ Frequency: ______________________

Time for Dosage: ____________________ Child will Self-Administer: ☐ Yes ☐ No

Route:______________________________ Date of RX: ______________________

Please provide a complete list of all symptoms that indicate that the child has come into contact with an allergen, that he/she requires emergency treatment or is in need of medication listed above.

____

____

Physician Name: ___________________________________ Address: ____

Phone Number: ___________________________________ Emergency Number: ______________________________

Signature: ____ Date: _____/_____/______

PART II (TO BE COMPLETED BY PARENT(S)/GUARDIAN(S))

☐ My child has the knowledge and skills to safely administer his/her medication, and is capable of self-administering their medication without assistance and is responsible with device.

Parent/Guardian Signature: __________________________ Date: _____/_____/______

By signing below, I/we authorize National Inventors Hall of Fame and its designated agents to follow the instructions as outlined in this form by my child's physician, including the administration of medication. I/We agree to update this form immediately if any changes take place. I further authorize National Inventors Hall of Fame and its designated agents to contact my child's physician listed above.

Parent/Guardian Signature: ____ Date: _____/_____/______

Parent/Guardian Signature: ____ Date: _____/_____/______

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