Date: [Insert Date]

To: [Clinic/Medical Center Name]
Address: [Clinic Street Address]
City, State, Zip: [City, State, Zip Code]

Subject: Emergency Epinephrine Auto-Injector Authorization

To Whom It May Concern,

I, [Parent/Guardian Name], hereby authorize the staff and medical professionals at [Clinic Name] to administer an emergency epinephrine auto-injector (such as an EpiPen) to my child, [Child's Full Name], born on [Child's Date of Birth], in the event of a suspected anaphylactic reaction.

Known Allergies: [List Allergies, e.g., Peanuts, Bee Stings]
Weight: [Insert Weight] lbs/kg
Dosage: [Insert Dosage, e.g., 0.3mg or 0.15mg]

I understand that this medication will be administered according to the clinic's emergency protocols and the instructions provided by a licensed healthcare provider. I also authorize clinic staff to contact emergency medical services (911) immediately following the administration of the medication.

Emergency Contact Information:

- **Primary Contact:** [Name] - [Phone Number]
- **Secondary Contact:** [Name] - [Phone Number]
- **Preferred Hospital:** [Hospital Name]

This authorization is valid from [Start Date] to [End Date/Indefinite].

Sincerely,

_____
[Parent/Guardian Signature]

[Parent/Guardian Printed Name]
[Phone Number]