New York State Department of Health
Bureau of Emergency Medical Services and Trauma Systems

Notice of Intent to Provide Epinephrine Auto-Injector

☐ Original Notification ☐ Update

Entity Providing Epinephrine Auto-Injectors

Name of Entity (ambulance service, ALSFR, BLSFR, children's camp, school, other)

Agency ID

Name of Primary Contact Person

( ) Telephone Number

Address

County

( ) Fax Number

City

NY State

Zip

E-Mail Address

Type of Entity (please check the appropriate box)

☐ Day Camp ☐ Traveling Day Camp ☐ Overnight Camp ☐ Ambulance Service ☐ ALSFR Agency ☐ BLSFR Agency ☐ School

Check all that apply: ☐ Nurses Office, Premises, or Infirmary ☐ Off-Site Trips/Events ☐ Other _____

Emergency Health Care Provider

Name of Emergency Health Care Provider (Physician)

NYS License #

( ) Telephone Number

Email

( ) Fax Number

Address

City

NY State

Zip

Number of Providers Trained to Use Auto Injector: _____

Minimum Number of Injectors to be Maintained On-Site: _____ Adult _____ Pediatric

Maximum Number of Injectors to be Maintained On-Site: _____ Adult _____ Pediatric

Authorization Names and Signatures

CEO/COO, Camp Director or Administrator (Please print) | Signature | Date

Physician (Please print) | Signature | Date

Complete and sign this form and submit the original to the appropriate Regional Emergency Medical Services.