Epinephrine Auto-Injector Medication Authorization

to access and use prescribed medications during school

ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ School Immaculate Conception HR/Grade _____

Healthcare Provider to Complete:

I verify this medication has been prescribed for above student in the event of signs or symptoms of an allergic reaction and/or suspected exposure to the following allergen(s): _____

Signs or symptoms _____

Medication_____**Strength/Concentration**_____ **Dosage**_____ **Route**_____

Beginning Date _____ Expiration Date_____ or end of school year

CALL 911 when medication is administered. Repeat dose if medication does not produce relief ☐yes ☐no

Other medications prescribed to this student (home & school) _____

THIS SECTION IS ONLY FOR THE PERMISSION TO SELF CARRY:

I provided the student with training in the use of an auto-injector and he/she has demonstrated its proper use. ☐ **yes** ☐ **no**

The student is capable of possessing and self-administering the auto-injector per ORC 3317.716 and 3313.718. ☐ **yes** ☐ **no**

Per state law, I prescribed a back-up auto-injector to be kept at school for as needed use by trained staff. ☐**yes** ☐**no**

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's epinephrine auto-injector will be stored in the school medication cabinet to ensure its availability and will have the assistance of trained staff as needed.

- If my student is determined capable to self-carry and self-administer by myself, the healthcare provider and the school nurse, then I authorize my student to carry and use their epinephrine auto-injector as prescribed above, at school and school events: ☐ **yes** ☐ **no.**
  - I will instruct my child to inform school staff if he/she has used the auto-injector so school staff can immediately call 911.
  - I agree to provide the school with backup dose of epinephrine as required by law.

- I understand emergency medical service will be called if the epinephrine auto-injector is used. I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize the school nurse to communicate with the student's healthcare provider about the medication as needed.
- I release and agree to hold the Immaculate Conception School, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____