(School Name)

SCHOOL HEALTH SERVICES

Authorization for Emergency Injection for Severe Allergy

NAME_____BIRTHDATE_____

ADDRESS:_____ _CITY:_____ZIP:_____

TELEPHONE_____PARENT/GUARDIAN: _____

I. PARENT/GUARDIAN PERMISSION: I hereby request and give permission for my child to be given Epinephrine while attending school and school sponsored activities that are off campus, according to written directions from my child's physician outlined below. I will notify the school immediately if the health status of my child changes, we change physicians, we change home, work or emergency telephone numbers, or there is a change or cancellation of the injection procedure. I have provided an Epi-Pen, Epi-Pen Jr. or similar auto-injector to the school, and understand that non-medically trained personnel may be responsible for its administration. The auto-injector will be provided by me and delivered to the school in good working order. I will replace the auto-injector prior to its expiration date. I will provide a nurse or other medical personnel to instruct non-medically trained personnel in the injection procedure and permission is hereby given for non-medically trained personnel to Inject the Epinephrine into my child as set forth herein in case my child is unable to self administer. I understand and assume the risks inherent with such emergency treatment, which may be beyond the reasonable control of the school and its staff and volunteers. I also understand that the school and the Diocese of St. Petersburg disclaim any and all responsibility for any such risks and I release the school and the Diocese of St. Petersburg, and their respective employees, representatives, volunteers and agents form any liability arising from such use and I hereby acknowledge and that I agree to assume all of the risks of loss, damage or injury that may occur.

MEDICATION EXPIRATION DATE: _____

SIGNATURE OF PARENT/GUARDIAN: _____DATE:_____

PRINCIPAL'S SIGNATURE _____DATE._____

II. PHYSICIAN'S ORDERS:

_____REQUIRES THE ADMINISTRATION OF_____

(Child's Name)

IN THE EVENT OF _____

MEDICATION: _____DOSAGE:_____

METHOD OF ADMINISTRATION: _____

OTHER INSTRUCTIONS _____

STUDENT MAY CARRY AND SELF ADMINISTER THE MEDICATION (PLEASE CHECK):YES____ NO____

PHYSICIAN'S SIGNATURE:_____DATE:_____

III. PERSONS DESIGNATED BY PRINCIPAL AND TRAINED TO ADMINISTER ABOVE MEDICATION (AT LEAST THREE REOUIRED)

NAME _____ DATE: _____

NAME _____DATE:_____

NAME_____ _____DATE:_____

SCHOOL NURSE'S SIGNATURE:_____DATE: _____

IV. RECORD OF DRUG ADMINISTRATION

ADMINISTERED BY: _____DATE._____

TIME:_____PARENT NOTIFIED:_____

REPLACEMENT OBTAINED: _____

A NEW AUTHORIZATION IS REQUIRED EACH SCHOOL YEAR

Form 2-2366