

# Authorization for Student Possession/Use of an Epinephrine Auto-injector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess/use an epinephrine auto-injector to treat anaphylaxis in school. Authorization form is valid for one school year. New forms must be submitted each school year.

|              |       |               |       |
|--------------|-------|---------------|-------|
| _____        |       | _____         |       |
| Student Name |       | Date of Birth |       |
| _____        |       | _____         | _____ |
| Address      | City  | ZIP           | Phone |
| _____        |       | _____         | _____ |
| School       | Grade | Teacher       |       |

## This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess/use an epinephrine auto-injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I also understand that a school employee may administer the epinephrine auto-injector if the child is unable to self administer it. I will provide a backup dose of the medication to the school principal or nurse as required by law.

|                              |               |            |            |
|------------------------------|---------------|------------|------------|
| _____                        | _____         | _____      | _____      |
| Name of Parent/Guardian      | Email Address | Home Phone | Cell Phone |
| _____                        |               | _____      |            |
| Signature of Parent/Guardian |               | Date       |            |

## This section must be completed and signed by the medication prescriber.

|  |                           |                 |
|--|---------------------------|-----------------|
| _____  | _____                     | _____           |
| Name and dosage of medication  | Administration Start Date | Expiration Date |
| _____  |                           |                 |
| Circumstances for use of the epinephrine auto-injector                                 |                           |                 |
| _____  |                           |                 |
| Procedures for school employees if the medication does not produce the expected relief |                           |                 |

Possible severe adverse reactions:

\_\_\_\_\_

To the student for which it is prescribed (that should be reported to the prescriber)

\_\_\_\_\_

To a student for which it is **not** prescribed who receives a dose

Other special instructions: \_\_\_\_\_

- As the prescriber, I have determined that this student is capable of possessing and using this auto-injector appropriately and have provided the student with training in the proper use of the auto-injector.
- Student is unable to self-administer the medication. A trained individual should use this auto-injector as prescribed.

|                                  |       |
|----------------------------------|-------|
| _____                            | _____ |
| Licensed prescriber signature    | Phone |
| _____                            | _____ |
| Licensed prescriber printed name | Date  |