JHCD-R

ALEXANDRIA CITY PUBLIC SCHOOLS
AUTHORIZATION TO ADMINISTER EPINEPHRINE AUTOINJECTOR FOR THE MANAGEMENT OF ACUTE EMERGENCY ALLERGIC REACTIONS

Name of student: _____ Grade: _____
School Year: _____ Name of School: _____
Birth Date: _____

PART I: TO BE COMPLETED BY PARENT/GUARDIAN:

I will supply medication to the school nurse and request that this medication be available in the school as prescribed by my student's physician. I agree to release, indemnify, and hold harmless Alexandria City Public Schools, their staff and agents from lawsuit, claim demand or action related to the use of this medication.

My child **IS _____ IS NOT**_____ capable of self-administration of the epinephrine autoinjector medication.

I DO _____ **DO NOT** ____ want my child to carry the epinephrine autoinjector medication during the school day.

The school nurse will release the epinephrine autoinector medication to the trained ACPS staff member accompanying my child on every field trip during the current school year unless I request otherwise.

Before allowing the student to carry an epinephrine autoinjector in school, the school nurse will review proper use with the student. The school nurse must sign that the student demonstrates proper knowledge before the student will be allowed to carry the epinephrine autoinjector medication.

Parent Signature: _____ Printed Name: _____
Contact Numbers: (H) _____ (W) _____(C) _____

PART II: TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

Name of medication**: _____ (EPINEPHRINE AUTO INJECTOR)**

Reason for medication: Management of acute allergic reaction to:
_____ a. stinging insects (bees, wasps, hornets, yellow jackets)
_____ b. ingestion of _____
_____ c. other _____
Medication to be given:
_____ a. immediately after insect bite
_____ b. immediately after ingestion of _____
_____ c. other _____
Route of administration: Intramuscularly into anterolateral aspect of thigh
Dosage of medication:
_____ Epinephrine Autoinjector 0.15mg _____ Epinephrine Autoinjector 0.30mg
Possible side effects: _____
Physician/Licensed Prescriber's Name: _____
(Signature) (Printed/Stamped)
Physician/Licensed Prescriber's contact number: _____ Date: _____

PART III: TO BE COMPLETED BY THE SCHOOL NURSE:

Check as appropriate:
_____ Part I and II listed above completed with all information
_____ Medication is properly labeled
_____ Medication label and dosage match physician's order
_____ I have reviewed the proper use of the Epi-Pen with the student and I
AGREE _____DISAGREE _____that the student should carry it during school hours.
Medication expiration date _____
Nurse: (Signature): _____ (Printed/Stamped): _____ Date: _____