2432 Greensburg Pike, Pittsburgh, PA 15221
Phone 412.244.1900 Fax 412-244-1902
Health Office Phone 412-342-4317 www.paceschool.org

AUTHORIZATION FOR ADMINISTRATION OF AN EPINEPHRINE AUTO-INJECTOR

Effective 2022/2023 School Year

including Extended School Year (ESY) 2023

Student Name: ________________________________ D.O.B.: ___/___/___

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

Licensed Health Care Provider's Name: ________________________________ Ph: ____________

Address: ________________________________ Fax: ____________

Diagnosis: ________________________________

Medication: ____________ Strength: ____________ Dose: ____________

Form: Auto-injector device

Time of Administration: **PRN for the signs and symptoms of a life threatening allergic reaction**

How soon can a second dose of the medication be administered: ____________

911 WILL BE CALLED IMMEDIATELY AFTER THE ADMINISTRATION OF THE FIRST DOSE AND THE STUDENT WILL BE TRANSPORTED TO AN APPROPRIATE MEDICAL FACILITY.

Indications for medication administration: Wheezing Shortness of Breath Coughing Chest Tightness

Difficulty swallowing Swelling of the face, lips tongue Loss of Consciousness **(PLEASE CIRCLE ALL THAT APPLY)**

Other indications: ________________________________
The medication cannot be repeated more than: ________________________________
Side Effects: ________________________________
Comments: ________________________________

Is the child knowledgeable about his/her emergency medication: **YES** **NO**
Has the child demonstrated the proper technique to administer the medication: **YES** **NO**
It is my professional opinion that ________________ **SHOULD NOT BE PERMITTED TO CARRY** and/or self-administer the epinephrine auto-injector.

Licensed Health Care Provider's Signature: ________________________________ Date: ___/___/___

FOR COMPLETION BY PARENT/LEGAL GUARDIAN

I, ________________________________, **DO NOT GIVE PERMISSION** for my child to carry and
(Print Parent/Legal Guardian Name)
self -administer the epinephrine auto-injector prescribed by his/her licensed health care provider. I hereby authorized the appropriate staff person at Pace School to administer the epinephrine auto-injector during school hours if my child begins to display the signs and symptoms of a life threatening allergic reaction. I also understand my child will be transported to the appropriate medical facility and I will be notified as soon as possible by the nurse or an administrator at Pace School. This consent is only for the current school year.

Parent/Legal Guardian Signature: ________________________________ Date: ___/___/______

Student Signature (if 14 years of age or older): ________________________________ Date: ___/___/______

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ORAL AUTHORIZATION – NOT APPLICABLE TO HIV RELATED INFORMATION

I witness that the person understood the nature of this consent and freely gave his/her oral authorization.
(Two witnesses are required)

Name of person giving oral authorization: ____

Relationship: ____ **Date:** ________________

Witness #1: ____ **Date:** ________________

Witness #2: ____ **Date:** ________________

The Parent/Legal Guardian was informed that a two person verbal consent may be obtained by the nurses initially to administer medications but the Parent/Legal Guardian are still required to sign the Permission to Administer Medication During School Hours form as soon as possible.