Buckeye Valley Local School District

Self Administration of Epinephrine Auto Injector Authorization Form

A completed Allergy Action Plan **must** accompany this form.

Student Name: _____Date of Birth_____
Student Address: _____
(street/apt. #/PO Box/city/zip code)
School: _____Grade:_____

Reason for carrying Epinephrine Autoinjector: Bee/Insect Sting Peanuts Tree Nuts Other
If other, please specify:_____
Medication: Epi-Pen© Epi-Pen, Jr.© Auvi-Q® 0.15 mg Auvi-Q® 0.30 mg Other
If other, please specify_____
Medication start date:_____ Medication end date:_____
Adverse reactions that should be reported to the physician : _____
_____

Other instructions: _____

By signing below, the physician or other health care provider and parent/guardian state that it is their request that the above student carry the epinephrine auto-injector on their person at school and any school function. They realize that because the student is self-administering medication, no adult may be aware that the student is experiencing difficulty, preventing adults from responding appropriately in an emergency; and that the student has been fully trained in the use of the epinephrine auto-injector , knows why, how and when to use it properly and will not give the epinephrine auto injector to any other student. In accordance to ORC 3313.718, the parent WILL provide a second epinephrine auto injector for the school clinic.

I understand 911 will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

In the event that the epinephrine auto-injector is abused or misused by the student or others, school personnel have the responsibility to assume control of the epinephrine auto-injector and contact the parent/guardian to assess the next best action for the student, classmates and others.

Physician Name: _____ Phone number:_____

Physician Signature:_____ Date:_____

Parent/Guardian Name:_____ Phone Number:_____

Parent/Guardian Signature:_____ Date:_____

By signing below, the above named student states an understanding of the circumstances of his/her specific allergy, symptoms of severe reaction or anaphylaxis, identify the need for epinephrine and mastery of technique of self administration of epinephrine as witnessed by another person. The above named student agrees to NEVER share the epinephrine auto-injector with another person. The student agrees to seek adult help IMMEDIATELY in the event of exposure to a known allergen (regardless whether or not epinephrine was administered).

Student Signature:_____ Date:_____

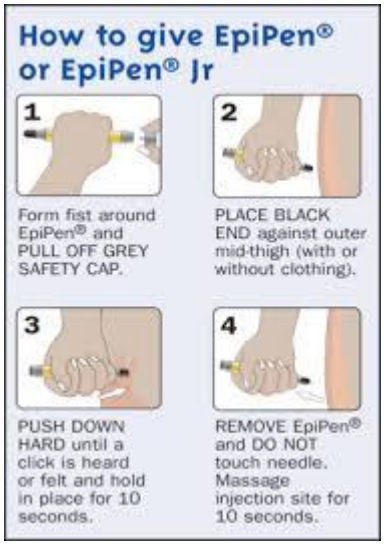
(continued on back)

Buckeye Valley Local School District

DIRECTIONS

Auvi-Q

Epi-Pen©



Once Auvi-Q® or Epi-Pen© is used,

CALL 911

Take the used, safely repackaged autoinjector unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours