Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

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 and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

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 and use an epinephrine autoinjector, 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 will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent/Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

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

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it 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

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

HEA 4222 3/07

Deer Park Community City Schools

Medication Evaluation for Self-Administered Drugs

EpiPen/Allergies

Student: _____ Grade: _____ Date: _____

Allergy: _____

1. My child has been trained in the proper use of his/her EpiPen. Yes _____No_____
2. My child knows the signs and symptoms of an allergic reaction. Yes _____No_____
3. My child is physically able to administer the EpiPen without assistance. Yes _____No_____
4. My child knows how often he/she may use the EpiPen. Yes _____No_____
5. My child is aware of adverse reactions that may occur. Yes _____No_____
6. My child is aware that he/she must report any use of an EpiPen to the school nurse or administration and 911 will be called. Yes _____No_____
7. I have read and understand the policy written in the Deer Park Handbook regarding the self-administration of an EpiPen. Yes _____No_____
8. I accept responsibility for my child's use of his/her EpiPen. Yes _____No_____

Plan of action for an Allergic Reaction:

_____

_____

Additional comments:

_____

_____

I have read and understand the "Use of Medications" section in the Deer Park School Student-Parent Handbook.

I have provided the school nurse with a backup dose of the student's medication. (Please check):

Yes _____ No _____

Parent/guardian name: _____ Phone: _____

Parent/guardian signature: _____ Date: _____

To be completed by the school nurse:

I verify that I have received a backup dose of the student's emergency medication.

Signature: _____ Date: _____

Location of medication: _____