



Hillsboro City Schools

Elementary- (937) 393-3132 Fax- (937) 393-2418

MS/HS- (937) 393-4421 Fax- (937) 393-5843

Self-Possession and Use of an Epinephrine Autoinjector

Dear Parents/Guardians,

Please consult the prescriber to determine if this medication is necessary to have at school and if it is appropriate, safe and feasible for your child to self-carry and self-administer an epinephrine autoinjector.

Before a student may possess and self-administer an epinephrine autoinjector in school, the State of Ohio law (Section 3313.718/3313.141 O.R.C.) requires the following:

1. The parent must complete and sign the parent portion of the Authorization form.
2. The licensed prescriber must complete and sign the provider portion of the form.
3. Both sections must be completed and returned **BEFORE** the student can carry the autoinjector at school.
4. The medication must be brought to school in the original container labeled with your child's name, the provider's name, the name of the medication, the dose, and the time it is to be taken.
5. A new form must be completed **EVERY** school year.

****It is recommended that a backup autoinjector be kept in the school clinic.**

These policies are for the health and safety of your child. If you have any questions, please contact the school nurse.

School Nurse
Katie Greer, RN, BSN

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