Authorization for Self-Administration of Anaphylactic Medications at School

Name of Student: _____ Birth Date: _____

School: _____ Grade: _____

School Year Start Date: _____ (All authorizations expire at the end of the school year)

Medication Orders?Other Considerations / Directions: _____

_____

☐ Student is knowledgeable about the medication and how to administer it.

☐ Student has the skills to safely possess and use an epinephrine auto-injector.

☐ Student may self-administer the epinephrine auto-injector and/or benadryl for severe allergic reaction.

_____

Print Name of Physician Physician Signature

_____

Clinic Address Phone Number Date

Parent / Guardian Authorization

I request that the above medication(s) be used during school hours as ordered by this student's physician / licensed prescriber in case of severe allergic reaction that might lead to anaphylaxis. I also request the medication(s) be administered on field trips or other school sponsored activities, as prescribed.

I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change in the medication(s) (ex: medication is discontinued, etc.).

I give permission for the school nurse to communicate with the student's teachers about the student's allergies which might lead to an anaphylactic reaction. In case of a severe allergic reaction, in addition to administration of either or both benadryl and epinephrine, 911 should be called as directed for standard treatment of anaphylaxis and parents notified immediately.

I give permission for the school nurse to consult with the above named student's physician / licensed prescriber regarding any questions that arise with regard to the listed medication(s).

☐ My son/daughter may self-administer his/her epinephrine device or medication used for an anaphylactic reaction.

_____

Parent/Guardian Name Signature Date

NOTE: Medication is to be supplied in the original container

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