SIDNEY CITY SCHOOLS

750 S. FOURTH AVENUE
SIDNEY, OHIO 45365
MAIN: 937-497-2200
FAX: 937-497-2211

AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR (EPI-PEN)

Student's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Parent/Guardian's Name: _____ Phone: _____

Provider's Name: _____ Provider's Phone: _____

Provider's Fax Number: _____

PROVIDER - PLEASE COMPLETE:

The above-named student is under my care and should receive:

Name of Medication in Autoinjector: _____ Dose: _____

Beginning date of request:_____ Expiration date of request: _____

The autoinjector should be used in the following circumstances: _____

_____

Procedure to follow if the student is unable to administer the anaphylaxis medication: _____

_____

Procedure to follow if the medication does not produce the expected relief from the student's anaphylaxis:_____

Adverse reactions that should be reported to the provider: _____

_____

Adverse reactions for unauthorized user: _____

Other special instructions: _____

Prescriber, please acknowledge:

The student is capable of possessing and using the autoinjector. ____ yes ____ no

The student has been trained on the proper use of the autoinjector. ___ yes ___ no

_____

Provider's Signature Date

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The school nurse or other designated trained personnel have been provided a backup dose of the student's medication. ___yes ___no

_____

Parent/Guardian Signature Date

Parents MUST bring medication to school in its original container and deliver it directly to the office.

Note: The parent/guardian of the child must assume responsibility for informing the Principal and school nurse of any change in the child's health or any change in the prescribed medication. Any change to the above prescription (dosage or administration) will require the completion of a new form.

_____

School Official's Signature (Acknowledging Receipt) Date

Office Use Only - Homeroom/Grade _____