

SOUTHAMPTON TOWNSHIP PUBLIC SCHOOLS

177 Main Street

Southampton, New Jersey 08088

Fax Number: (609) 859-1542

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION FOR EPINEPHRINE VIA AUTO-INJECTOR FOR ANAPHYLAXIS

SCHOOL YEAR_____

STUDENT'S NAME:_____ **DOB:**_____ **GR.**_____

Completed by Physician

Diagnosis/Allergy(s):_____

Medication:_____

Dose and Frequency:_____

Indication for use:_____

Side Effects:_____

I verify that the above named student has been adequately trained in the use of his/her medication, therefore, is capable of carrying and self-administering the above named medication for anaphylaxis provided that the pupil does not endanger him/herself or other persons through misuse.

Doctor's Name:_____ **Signature:**_____ **Date:**_____

Physician's Number:_____ **Physician's Address:**_____

Completed by Parent/Guardian **Agreement for Self-Administration of Medication**

I request that my child be permitted to carry and self-administer their medication for anaphylaxis as listed above. I verify that I have observed my child technique on self-administering his/her medication and is competent to do so. In signing this form I acknowledge that the Southampton Township School District shall incur no liability as a result of injury arising from the self-administration of medication for anaphylaxis. I shall indemnify and hold harmless the Southampton Township School District and its employees, including school nurse, or any other officer or agents of the board of education against any claims, arising out of the self-administration of medication by my child.

Parents the following guidelines will be used for the self-administration of epinephrine via auto-injector:

1. This request for self-administration of epinephrine for anaphylaxis must be done annually for each school year.
2. Parents should instruct their child to keep the medication for anaphylaxis with them at all times and labeled with name and allergy. Parent is to supply ALL medications.
3. It is recommended that "back up" medication be kept in the Nurse's Office.
4. Parents are to instruct their child that whenever they self-administer their medication they are to inform teacher, coach, or other individual in charge and 911 will be called. Also nurse needs to be informed.

PARENT/GUARDIAN NAME:_____ **SIGNATURE:**_____

PARENT/GUARDIAN NAME:_____ **SIGNATURE:**_____

DATE OF AGREEMENT:_____

OFFICE USE ONLY:

Building Principal:_____ **School:**_____