



AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTO INJECTOR

Student Name: _____ Date of Birth: _____

Student Address: _____

School: _____ Grade: _____ Teacher: _____

- Section I must be completed by the student's State licensed health professional authorized to prescribe drugs ("prescriber").
- Section II must be completed and signed by the student's parent/guardian.
- A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine auto injector to treat anaphylaxis in school.

I. PRESCRIBER'S SECTION

This is to certify that the above named student is under my care and self-possess and use the below epinephrine auto injector.

Medication	
Dose/Route	
Procedures for school employees if the medication does not produce the expected relief	
Severe adverse reactions to be reported to prescriber	
Start & end date of this request	Start _____ End _____

As a licensed health professional in the State of Ohio, and at the request of this student's parent/guardian, I direct that the above medication be self-administered as indicated above.

Prescriber's printed name and title: _____

Prescriber's signature: _____ Date: _____

Address: _____

Phone: _____

II. PARENT/GUARDIAN'S SECTION

As the Parent/Guardian of the above named child, I authorize my child to possess and use an epinephrine auto injector, 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.

I do hereby release the Board of Education and all school employees from any and all liability for damages or injury resulting directly from this authorization.

I am responsible for the delivery of this medication to the school clinic and will notify the school immediately if the need for this medication is discontinued.

I agree to submit a revised *Authorization for Student Possession and Use of an Epinephrine Auto Injector* form if any changes are made regarding the above medication, or if we change our health professional

If this medication is required during district-sponsored overnight activities, I agree to provide a separate dose to trained school staff supervising my child's overnight activities. I agree to submit a revised *Authorization for Student Possession and Use of an Epinephrine Auto Injector* form to include prescriber instructions outside of regular school hours.

I consent to communication between the prescriber or their clinic, the school nurse, and designated staff as necessary for my child's medication management.

Parent/Guardian's printed name: _____

Parent/Guardian's signature: _____ Date: _____