

TROY CITY SCHOOLS

Authorization for Student Possession and Use Of an Epinephrine Auto-injector

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 auto-injector to treat anaphylaxis in school.

Student Name: _____ Grade: _____ Date of Birth: _____

Street 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 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. Further, we (I) give consent for the school nurse/clinic assistant to communicate with the physician's office in regard to this medication order.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Emergency Phone #: _____

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) _____

Circumstances for use of the epinephrine auto-injector (diagnosis/allergy): _____

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 which it is prescribed (that should be reported to the prescriber): _____

To the student for which 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 auto-injector appropriately and have provided the student with training in the proper use of the auto-injector.

Prescriber's Signature: _____ Date: _____

Prescriber's Printed Name: _____ Phone #: _____ Fax: _____