

PICKERINGTON LOCAL SCHOOL DISTRICT

Authorization for Student Possession and Use of an Epinephrine Autoinjector

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

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| Student name |
| Student 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 autoinjector, 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.

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| Parent/guardian signature | Date |
| Parent/Guardian name | Parent / Guardian emergency telephone # () |

This section must be completed and signed by the medication prescriber.

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| Name and dosage of medication | |
| Date medication administration begins | Date medication administration ends (if known) |

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| Circumstances for use of the epinephrine autoinjector |
| 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:

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| To the student for which it is prescribed (that should be reported to the prescriber) |
| To a 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 autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

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| Prescriber signature | Date |
| Prescriber name | Prescriber emergency telephone number () |