St. Joseph's Catholic School
11011 Montgomery Road
Beltsville, MD 20705

Physician Authorization for Administration
of Emergency Medication – EpiPen
For Management of an Acute Allergic Reaction

FOR COMPLETION BY PARENT OR LEGAL GUARDIAN

Full Name of Student_____ School Year _____
Known Medication or Food Allergies _____
_____

No medication will administered by the RN or designated Certified Medication Technician, without the prior authorization of the student's Physician and the consent of the parent or legal guardian. THIS FORM, WITH PROPER AUTHORIZATION MUST BE ON FILE.

St. Joseph's School shall have no liability as a result of any injury arising from the administration of a pre-filled, single dose auto injector mechanism containing Epinephrine. I shall indemnify and hold harmless St. Joseph's School and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto injector containing epinephrine to my child in accordance with authorization provided by my child's physician and myself. I will be responsible for obtaining the prescription and the signed consent from my child's physician and for providing the school with an appropriate amount of Epinephrine Auto Injectors and for replacing any expired Epinephrine Auto Injector on a timely basis. I understand that this entire consent *must be renewed annually*.

_____
_____
(Printed Name of Parent/Legal Guardian) (Signature of Parent Legal Guardian / Date

FOR COMPLETION BY THE STUDENT'S PHYSICIAN – PLEASE PRINT

I _____ authorize the administration of :
(Print Physician Name – NO STAMPS)

1. EpiPen (Epinephrine Auto-Injector) __ EpiPen 0.15 mg or __ EpiPen 0.3 mg. (check one)
2. Reason for medication: Emergency management of *acute allergic reactions of*: (Check one) _____ a. Stinging Insect
_____ b. Ingestion of _____
(Specify)
3. Medication is to be given: (Check one) ___ a. Immediately after insect sting; ___
b. Immediately after ingestion of _____; or ___ c. _____
(Other – specify)
4. Route of administration: Auto-Inject into anterolateral aspect of thigh or other specified body part_____
5. Side effects that may occur _____
_____
6. *911 WILL BE CALLED IMMEDIATELY & STUDENT WILL BE TRANSPORTED TO THE CLOSEST AVAILABLE HOSPITAL*

(PLEASE COMPLETE BOTH SIDES OF FORM)

FOR COMPLETION BY PHYSICIAN AND PARENT/GUARDIAN

I understand that all medications, prescription and non-prescription, must be hand-delivered to the school with the proper labels and authorizations, in the original packaging. *THEY MUST BE GIVEN TO THE SCHOOL RN or CERTIFIED MEDICATION TECHNICIAN.* UNDER NO CIRCUMSTANCE WILL ANY MEDICATIONS, PRESCRIPTION OR NON-PRESCRIPTION, BE ADMINISTERED WITHOUT THE PRIOR PHYSICIAN AUTHORIZATION AND PARENT/LEGAL GUARDIAN APPROVAL. *UNDER NO CIRCUMSTANCE MAY A STUDENT HAVE ANY MEDICATION, PRESCRIPTION OR NON-PRESCRIPTION, IN HIS/HER POSSESSION, NOR MAY THEY BE SELF-ADMINISTERED.*

_____ _____

Physician's ORIGINAL Signature (NO STAMPS) (Date) (Office Tel. #)

_____

Physician's PRINTED NAME

_____ _____

(Physician's Address – NO STAMPS PLEASE) (Physician's *EMERGENCY CONTACT* #)

_____

(Signature of Parent or Legal Guardian) (Printed Name of Parent or Legal Guardian)

_____

(*EMERGENCY CONTACT NUMBER* for Parent(s) / Legal Guardian)

Reviewed by RN

_____

(Name) (Date)