

**CIRCLEVILLE CITY SCHOOLS
AUTHORIZATION FOR STUDENT POSSESSION
AND USE OF EPINEPHRINE AUTOINJECTOR**

NAME _____ PHONE _____

ADDRESS _____

BIRTHDATE _____ SCHOOL _____ GRADE/ROOM _____

Physician's Section

_____ is under my care and should be allowed to carry and administer
his/her personal 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.

Student Name

_____ **Medication Name**

Dosage, Frequency, and Time of Administration

The student has been instructed and has demonstrated knowledge to the parent and/or physician of the proper circumstances in which this medication should be administered, as well as its proper storage and care.

Possible side effects or severe adverse reactions to observe in the student are: _____

Procedures to follow in the event that the medication does not produce the expected relief:

Prescription start date _____ Prescription ending date _____

Date form completed _____ Physician's Signature _____

Physician printed name _____ Phone _____

Parent/Guardian Section

I request and give permission for my child to administer his/her epinephrine autoinjector in keeping with the **Physician's Section** above. Further, I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization. I further agree to submit a revised statement signed by the physician who has prescribed the medication described in the **Physician's Section** above, in the event that I become aware that any of the information has changed. 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 SCHOOL NURSE AS REQUIRED BY LAW.** I have read and understand the policy of Circleville City Schools for the administration of medication and affirm that this request entails special circumstances justifying an exception from the usual administration of medication by school personnel.

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____ Phone _____

Work Phone _____ Cell Phone _____ Pager _____

