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
Student Name
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. ______________________.
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________________

N 70-08