



One Family in Christ Jesus

PERMISSION FOR EMERGENCY ADMINISTRATION OF EPINEPHRINE

This order must be returned in its original form, fax/copies will not be accepted.

I, the parent/guardian of _____ authorize my child, a student at St. Joseph Regional School to be administered a pre-filled, single dose auto-injector mechanism containing epinephrine (provided by me) prescribed by our physician/nurse practitioner as described below for anaphylaxis since he/she has a documented history of anaphylaxis and does not have the capacity for self-administration of the medication. A faculty member/administrator has been designated to administer a pre-filled, single dose auto-injector mechanism containing epinephrine for anaphylaxis to my child. The designee has been properly trained by the school nurse using the "Protocol and Implementation plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" established by the Department of Education in consultation with the Department of Health and Senior Services. ***(does not guarantee the school nurse or designee will be available during all school hours)**

I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. **I further understand that neither the Somers Point Board of Education, any district employee, chief school administrator of a nonpublic school, nor nonpublic school employee shall be responsible for any liability as a result of any injury arising from the procedures utilized for emergency administration of epinephrine to my child and that I shall indemnify and hold harmless the district or nonpublic school and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child.**

Parent/guardian _____

Date _____

Physician's/Nurse Practitioner Authorization/Assurance Statement for Emergency Administration of Epinephrine

I certify that _____ is under my care for _____, a life-threatening condition and has a documented history of anaphylaxis. I am recommending that the above named student be administered a pre-filled, single dose auto-injector mechanism containing epinephrine for anaphylaxis since he/she does not have the capacity for self-administration of medication.

Name and purpose of medication: _____

Indications for emergency administration of epinephrine (specific signs/symptoms): _____

Identification of chronic medical problems: _____

Prescribed dosage and schedule: _____

Length of time medication to be taken: _____

Possible side effects and/or special precautions: _____

Prescribing Physician/Nurse Practitioner signature and date:

Please print name, address and telephone number of prescribing physician:
