DAYTON PUBLIC SCHOOLS

Dayton Public Schools—Health Services

Authorization for Student Possession and Use of an Epinephrine Auto-injector

In accordance with ORC 3313.718

Parent to Complete

_____

Student Name

_____

Address Telephone Number

_____

Date of Birth School Room Number

To the Parent or Guardian:
THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES OR USES PRESCRIBED MEDICATION IN SCHOOL; BOTH THE PARENT AND PHYSICIAN PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification order on this form.
2. I will assume responsibility for the safe delivery of the medication to school, either by me or by the student, or a responsible adult.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I authorize Dayton Public Schools Health Services personnel to communicate with my child's health care provider as necessary concerning the use of this medication.
5. I understand the Dayton Public Schools, members of the board of education or school district employees are not liable in damages in a civil action for injury, death, or loss to person or property arising from prohibiting a student to use an auto-injector because of the employee's good faith belief that the conditions set forth in ORC 3313.718 have not been satisfied, or for allowing the student to use the auto-injector if the conditions have been satisfied or from the use of the auto-injector by an unauthorized user.

As the parent/Guardian of the above named student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event or program sponsored by, or in which the student's school is a participant. I will instruct my child to inform school personnel if he/she has used the auto-injector so that the school employee can immediately call 911. I will provide a backup dose of the medication to the principal or school nurse as require by law to be administered by school personnel.

_____

Signature of Parent or Guardian **Date**

_____

Home Telephone **Work Telephone** **Cell Phone**

Emergency Contact Numbers: _____ _____
(Telephone Number) (Name and relationship to student)

_____ _____
(Telephone Number) (Name and relationship to student)

Reverse side to be completed by Healthcare Provider

PERMISSION TO CARRY AND SELF-ADMINISTER
EPINEPHRINE AUTO-INJECTOR (EpiPen)

Physician to Complete

I verify that this medication must be taken by _____
(Student's Name)
_____ at school and any activity, event, or program sponsored by or in which the student's school
(Date of Birth) is a participant.

_____
(Medication) (Dosage) (Route)

Beginning Date _____ Expiration Date _____

The following information must be completed by the Healthcare Provider prescribing the epinephrine auto-injector.

Circumstances in which the auto-injector should be used: (include allergies causing anaphylaxis).

Procedures to follow in the event that the student is unable to administer the anaphylaxis medication or the medication does not produce the expected relief from the student's anaphylaxis:

Adverse reactions that should be reported to the healthcare provider:

Adverse reactions for unauthorized user:

As the above named student's healthcare provider I have determined that the student is capable of possessing and using the auto-injector appropriately and I have provided the student with training in the proper use of the auto-injector. According to state law I have prescribed a back-up auto-injector to be kept and given by the school nurse or a trained designated school employee when the school nurse is not available.

Healthcare Provider's Signature _____ Date _____

Healthcare Provider's Emergency Telephone Number _____

Healthcare Provider's Printed Name or Official Stamp:

Reverse side to be completed by Parent