AUTHORIZATION FOR ADMINISTRATION OF INJECTABLE MEDICATION IN EMERGENCY SITUATION AT SCHOOL

Student's Name_____Birthdate_____

School_____ Grade_____

TO BE COMPLETED BY THE PRESCRIPTIVE LICENSED HEALTH PROFESSIONAL

NAME OF MEDICATION	**DOSAGE**	**METHOD OF ADMINISTRATION**
_____	_____	_____

THE ABOVE NAMED STUDENT SUFFERS FROM AN ALLERGY WHICH MAY RESULT IN AN ANAPHYLACTIC REACTION. THE PRECIPITATING ALLERGEN IS:

ANTICIPATED SYMPTOMS OR TIME LAPSE FROM EXPOSURE TO THE ALLERGEN NECESSITATING THE ADMINISTRATION OF THE ABOVE MEDICATION ARE:
(Please note that in most circumstances an unlicensed person would be in attendance at the time of emergency.)

FOLLOWING ADMINISTRATION OF THE ABOVE MEDICATION, THE FOLLOWING STEPS ARE TO BE TAKEN: (Call 911, transport to local hospital via ambulance, etc.)

IS IT NECESSARY FOR THE STUDENT TO CARRY THE ABOVE MEDICATION ON HIS/HER PERSON?

YES _____ NO _____

IS THE STUDENT CAPABLE OF SELF-ADMINISTRATION OF THE ABOVE MEDICATION?

YES _____ NO _____

I request and authorize that the above named student be administered the above identified medication in accordance with the explicit instructions provided by me as there exists a valid health reason which makes the administration of the medication necessary while the student is under the supervision of school officials. Such medication may be administered by medically untrained school personnel. This permission will be valid for the current school year only.

_____ _____
Date of Signature Prescriptive Licensed Health Professional Signature

_____ _____
Telephone Number Printed Prescriptive Licensed Health Professional Name

_____
Address

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THIS PORTION OF THE FORM IS TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian or other person in legal control of the above identified student and request and authorize the school personnel to administer the above medication to the above identified student as per specific instructions of the above named prescriptive licensed health professional. I understand that this will be an emergency situation and that a medically untrained person may be administering the medication. This permission will be valid for the current school year only.

The medication will be supplied by the parent in a commercially pre-measured single dose unit and will be labeled appropriately for the above student.

Date of Signature		Parent/guardian Signature
Work Phone	Home phone	Parent/guardian Printed Name
Work Phone #2		Employer's Name

4/11/01