AUTHORIZATION TO ADMINSTER EPI-PEN JR., EPINEPHRINE AUTO-INJECTOR

TO BE FILLED OUT BY PRESCRIBING HEALTH CARE PROVIDER

NAME OF STUDENT_____ DIAGNOSIS_____

NAME OF MEDICATION_____

DOSAGE_____

FREQUENCY AND DIRECTIONS _____

DESCRIPTION OF PROCEDURE_____

PURPOSE OF DRUG/PROCEDURE_____

SIDE EFFECTS_____

Appropriate for school nurse to give	Yes	No
Appropriate for unlicensed assistive individual to give	Yes	No
Appropriate for student self-administration	Yes	No

Signature_____ Date_____
Health Care Provider

_____ _____
Address Telephone Number

TO BE FILLED OUT BY PRESCRIBING PARENT/GUARDIAN

I authorize the nonpublic school nurse/principal/administrator to contact my primary health care provider on any questions related to my child's care. I also authorize the nonpublic school nurse, or other unlicensed assistive individual educated by the nurse to administer the above medication to my child during regular school hours. I authorize my child, who has been trained by his physician, to engage in self-administration of the epi-pen if appropriate. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; and that I will indemnify and hold harmless The Board of Education/School District, Bergen County Department of Health Services and their employees, school, school nurses and other school employees against any claims arising from the administration to my child.

Signature_____ Date_____
Parent/Guardian

TO BE FILLED OUT BY NONPUBLIC SCHOOL NURSE IF APPROPRIATE

Orders reviewed during telephone conversation with prescribing practitioner.

Signature_____ Date_____
Nurse