

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

| |
|-----------------|
| Student name |
| Student address |

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an 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. 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 nurse as required by law.

| | |
|---------------------------|---|
| Parent/Guardian signature | Date |
| Parent/Guardian name | Parent/Guardian emergency telephone number () |

This section must be completed and signed by the medication prescriber.

| | |
|---------------------------------------|--|
| Name and dosage of medication | |
| Date medication administration begins | Date medication administration ends (if known) |

| |
|---|
| Circumstances for use of the epinephrine autoinjector |
| Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief |

Possible severe adverse reactions:

| |
|---|
| To the student for which it is prescribed (that should be reported to the prescriber) |
| To a student for which it is not prescribed who receives a dose |

| |
|----------------------|
| Special instructions |
|----------------------|

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

| | |
|----------------------|--|
| Prescriber signature | Date |
| Prescriber name | Prescriber emergency telephone number () |

Developed in collaboration with the Ohio Association of School Nurses.

Emergency Action Plan for student with _____

Student name: _____ Age: _____ DOB: _____

Known Allergies: _____

List other additional information or significant special health concerns of this student:

***ACTIONS TO BE TAKEN:**

Medication if needed: _____

Important Emergency numbers:

Father /Guardian: _____

Phone:

Cell _____

Work _____

Home _____

Mother/Guardian: _____

Phone:

Cell _____

Work _____

Home _____