Madison Local School District

Madison Elementary School (513) 420-4755, (513) 420-4915 Fax
Madison Junior-Senior High School (513) 420-4760, (513) 420-4914 Fax

AUTHORIZATION FOR STUDENT POSSESSION AND USE OF AN EPINEPHRINE AUTOINJECTOR

(In accordance with Ohio Revised Code 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.

Name of Student_____ Birth Date_____
Student's Address_____
Street City Zip Code
School_____Class/Grade_____

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 Printed_____

Parent/Guardian Emergency Telephone Number_____

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE MEDICATION PRESCRIBER:

Medication_____ Dosage_____

Date to Begin_____ Date to end (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 the 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 Printed_____

Prescriber Emergency Telephone Number_____