



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 parent or guardian of the student.

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 NAME:	DATE:
PARENT GUARDIAN SIGNATURE:	PARENT/GUARDIAN EMERGENCY #: ()

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

NAME AND DOSAGE OF MEDICATION:	
DATE MEDICATION ADMINISTRATION BEGINS:	DATE OF MEDICATION ADMINISTRATION ENDS (IF KNOWN):
CIRCUMSTANCES FOR USE OF THE EPINEPHRINE AUTOINJECTOR	
PROCEDURES FOR THE SCHOOL EMPLOYEES IF THE STUDENT IS UNABLE TO ADMINISTER THE MEDICATION OR 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:	
PHYSICIAN NAME:	DATE:
PHYSICIAN SIGNATURE:	PHYSICIAN EMERGENCY TELEPHONE #: ()

REVISION: JK 7/28/24

