AUTHORIZATION TO ADMINISTER EPINEPHRINE

Name of Student:_____Grade:_____

(To Be Completed by Physician or Advanced Practice Nurse)

The Student named above requires administration of epinephrine for anaphylaxis, and does not have the capability to self-administer the medication.

Dosage:_____

Special Instructions:_____

Description of Emergency Situation:_____

Possible Side Effects:_____

_____ _____
Signature of Physician/Advanced Practice Nurse Date

_____ _____
Address Phone

PARENT/GUARDIAN AUTHORIZATION AND ACKNOWLEDGEMENT

I/We hereby authorize OLMC to administer epinephrine via epi-pen to the student named above, in accordance with New Jersey law and the Academy policy stated below, as stated in the orders of the physician/advanced practice nurse above. This authorization includes the Nurse or, in the absence of the Nurse, another Academy employee designated and trained by the Nurse in accordance with New Jersey law. I/We acknowledge receipt of written notice from the Academy that, provided the procedures set forth in New Jersey law and Academy policy are followed, the Academy and its employees or agents shall have no liability as a result of any injury arising from administration of the epi-pen to the Student. I/We understand and agree that to indemnify and hold harmless the Academy and its employees or agents against any claims arising out of administration of the epi-pen to the Student. I/We understand this authorization and these agreements are effective for the duration of the current academic year.

_____
Signature of Parent/Guardian

_____
Signature of Parent/Guardian

_____
Date