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

TO BE FILLED OUT BY PRESCRIBING HEALTH CARE PROVIDER

NAME OF CHILD _____ 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

TO BE FILLED OUT BY 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 nurse and other school employees against any claims arising from the administration to my to my child.

Signature _____ Date _____
Parent/Guardian

TO BE COMPLETED BY NONPUBLIC SCHOOL NURSE IF APPROPRIATE

Orders reviewed during telephone conversation with prescribing practitioner.

Signature_____ Date_____
Nurse