WARWICK SCHOOL DISTRICT
EPINEPHRINE AUTO-INJECTOR SELF ADMINISTRATION
AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN:

STUDENT'S NAME_____ BIRTHDATE_____

TEACHER/GRADE_____

By signing below:

1. I authorize the Warwick School District and its employees to allow my child to possess and use his/her Epinephrine Auto-Injector (a.) while in school, (b.) while at a school-sponsored activity, (c.) while under the supervision of school personnel and/or (d.) before or after school.
2. I agree that my child will demonstrate to the school nurse the proper use and technique for self administration of the Epinephrine Auto-Injector.
3. I agree that my child will notify the school nurse or qualified school personnel immediately following each use of the Epinephrine Auto-Injector and 911 will be called per district policy.
4. I acknowledge that the school bears no responsibility for ensuring that the medication is taken or properly self administered. It is recommended for the protection of the child that a second Epinephrine Auto-Injector be kept in the nurse's office in case the student does not have his/her Epinephrine Auto-Injector.
5. I agree that the school nurse may contact my child's health care provider for the release and exchange of information concerning my child's diagnosis and treatment.
6. I understand that neither the district nor any of its employees shall be held liable for any injury resulting from self-medication, and I agree to indemnify and hold harmless the school district and its agents against any related claims.
7. I agree that if my child abuses or ignores this privilege, school personnel may confiscate the Epinephrine Auto-Injector and the district will remove my child's privilege to carry the medication.

_____ _____
Parent/Guardian Signature Date

TO BE COMPLETED BY THE STUDENT'S HEALTH CARE PROVIDER:

Medication _____ Dosage_____

Time and frequency to be administered _____

Diagnosis_____

Possible Side Effects_____

As the health care provider for this student, I verify that he/she has been taught proper use of his/her Epinephrine Auto-Injector, has adequate knowledge of his/her allergy and how to control it, and is thought to be responsible enough to carry his/her Epinephrine Auto-Injector and use it properly without supervision.

_____
Physician's Printed Name Address Phone

_____
Physician's Signature Date Fax Number

NOTE: REQUESTS ARE EFFECTIVE FOR ONE SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY OR WHEN THERE IS ANY CHANGE IN PRESCRIPTION

WARWICK SCHOOL DISTRICT

FOOD / SUBSTANCE ALLERGY EMERGENCY CARE PLAN

Name of Student: _____ **Grade/Teacher:**_____

The above named student is allergic to the following foods and/ or substances: _____

_____

The above student has experienced the following symptoms: _____

_____

This student **( ) does/ ( ) does not** have asthma. Students with asthma are at an increased risk for severe allergic reactions. Accidental ingestion of the allergic food or substance could lead to a severe anaphylactic reaction. Early signs of an allergic reaction include the following symptoms:

MOUTH: Itching and/ or swelling of the lips, tongue, or mouth.
THROAT: Itching and/ or a sense of tightness in the throat, hoarseness, and/ or cough.
SKIN: Hives, itchy rash, and/ or swelling about the face, arms, or legs.
GUT: Nausea, stomach cramps, diarrhea, and/ or vomiting.
LUNG: Difficulty breathing, coughing, and/ or wheezing.
HEART: Weak pulse and loss of consciousness.

The **severity** of these symptoms can change **very** quickly. All of the above symptoms can potentially progress to a life-threatening situation! **Please make sure that your child is aware of his/her allergy and the need to inform an adult if he/she is exposed to the food or substance.**

If accidental ingestion or exposure to the food and/ or substance occurs, please check the following procedure(s) you would like the school nurse to follow:

( ) Give Benadryl orally to my child, 12.5 mg to 50 mg, as per the standing medication order from the school physician.

( ) Give medication as prescribed by my child's physician. Parents must provide the medications with the **written orders** from the child's physician **each** school year. **NOTE:** Parents who request that the student self-carry his or her Epinephrine Auto-Injector must complete the Epinephrine Auto-Injector Self Administration Authorization form **each** school year.

( ) Call 911 and have my child transported by ambulance to the hospital if signs of a severe allergic reaction develop. **NOTE: School Policy requires that 911 be called if epinephrine is administered.**

( ) Call Mother _____ (Phone #) Father _____ (Phone #) Emergency Contact _____ (Phone #)

( ) Call physician, Dr. _____ at phone number: _____.

( ) Other Instructions: _____

Note: **You are encouraged to alert all other school and after-school personnel (transportation, cafeteria, coaches, etc.) who may have contact with your child, so that they are aware of your child's diagnosis and treatment that may be needed.**

Parent Signature:_____ **Date:** _____