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