GREATER ESSEX COUNTY DISTRICT SCHOOL BOARD

Request and Authorization for the Administration of Epinephrine Auto-Injector at School

receives the medication prescribed by:	Appendix 1	Anaphylaxis (Sever	e Allergic Shock)	and Epinephrine Auto Injector -	– Student
receives the medication prescribed by:					
receives the medication prescribed by:	I request that	School	ensures that _	Name of Student	
Notes: 1. The medication provided must be provided in the ORIGINAL prescription container, labeled with the name of the medicine, the physician's name, the amount to be taken and the time(s) to be taken, and the student name. Prescription Number:					
of the medicine, the physician's name, the amount to be taken and the time(s) to be taken, and the student name. Prescription Number:	receives the n	nedication prescribed by:			as attached.
2. Authorization must be signed by the student or, in the case of a minor, by the parent or legal guardial whichever is the appropriate legal authority. In the case of a person who is disabled to such a degree as the incapable to give consent, the next of kin may authorize the administration of medicine. 3. It is understood that every attempt will be made to administer the medication at the requested time. On behalf of and myself, I hereby RELEASE THE BOARD , Name of Student its agents, officers, officials and employees from any and all liability and from any and all actions, causes or actions, claims and demands of any nature arising out of or in any way related to the dispensing of the medication referred to herein by the said Board, its agents, officers, officials or employees. Date:	Notes: 1.	of the medicine, the physici			
whichever is the appropriate legal authority. In the case of a person who is disabled to such a degree as t be incapable to give consent, the next of kin may authorize the administration of medicine. 3. It is understood that every attempt will be made to administer the medication at the requested time. On behalf of and myself, I hereby RELEASE THE BOARD , Name of Student its agents, officers, officials and employees from any and all liability and from any and all actions, causes o actions, claims and demands of any nature arising out of or in any way related to the dispensing of the medicatio referred to herein by the said Board, its agents, officers, officials or employees. Date: Signed:		Prescription Number:			
On behalf of and myself, I hereby RELEASE THE BOARD, Name of Student and myself, I hereby RELEASE THE BOARD, Name of Student and myself, I hereby RELEASE THE BOARD, search and demands of any nature arising out of or in any way related to the dispensing of the medication referred to herein by the said Board, its agents, officers, officials or employees. Date: Signed: (parent/guardian/student [if not a minor]) TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN The following medication has been prescribed. It is necessary for this medication to be administered during school hour by personnel other than the parent/legal guardian: Medication/Dosage/Method of Administration:	2.	whichever is the appropriat	e legal authority.	In the case of a person who is	disabled to such a degree as to
Name of Student its agents, officials and employees from any and all liability and from any and all actions, causes of actions, claims and demands of any nature arising out of or in any way related to the dispensing of the medication referred to herein by the said Board, its agents, officers, officials or employees. Date:	3.	. It is understood that every a	attempt will be ma	ade to administer the medication	n at the requested time.
its agents, officers, officials and employees from any and all liability and from any and all actions, causes of actions, claims and demands of any nature arising out of or in any way related to the dispensing of the medication referred to herein by the said Board, its agents, officers, officials or employees. Date:	On behalf of _			and myself, I hereby RE	LEASE THE BOARD,
actions, claims and demands of any nature arising out of or in any way related to the dispensing of the medication referred to herein by the said Board, its agents, officers, officials or employees. Date:		Name of Stud	dent	· · ·	
The following medication has been prescribed. It is necessary for this medication to be administered during school hour by personnel other than the parent/legal guardian: Medication/Dosage/Method of Administration: Indications for Administration: Other Instructions: Cautions/Notable Side Effects: Period of Authorization: From: Prescribing Physician's Name: Address: Date: Signed:		-	•		minor])
by personnel other than the parent/legal guardian: Medication/Dosage/Method of Administration: Indications for Administration: Other Instructions: Cautions/Notable Side Effects: Period of Authorization: From: Prescribing Physician's Name: Address: Date:		TO BE CO	MPLETED BY T	HE PRESCRIBING PHYSICIAN	1
Indications for Administration:Other Instructions:				ary for this medication to be ac	Iministered during school hours
Other Instructions:	Medication/Do	sage/Method of Administrat	ion:		
Cautions/Notable Side Effects:	Indications for	Administration:			
Period of Authorization: From: To: Prescribing Physician's Name: Address: Telephone Number: Date: Signed:	Other Instruct	ions:			
Prescribing Physician's Name: Telephone Number: Date: Signed:	Cautions/Not	able Side Effects:			
Address: Telephone Number: Date: Signed:	Period of Auth	norization: From:		То:	
Date: Signed:	Prescribing Pl	nysician's Name:			
Date: Signed:	Address:			Telephone Number:	
Duccasibing Development	Date:	S	ligned:		
Prescribing Physician				Prescribing Physician	

Note: This form is valid until the prescription expires or is altered by the physician, whichever comes first. It is the responsibility of the parent/guardian/student to ensure that a new form is completed when required and returned to the school. Any cost associated with the completion of this medical request is the sole responsibility of the parent/guardian.