Canton City School District
Health Services
Epinephrine Autoinjector Authorization

Student Name_____ DOB_____

School_____ Grade_____ Teacher_____

Allergies_____

This form must be completed fully, in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of medication administration.

- ➔ Each Epinephrine Autoinjector must be in a container labeled by the pharmacist or prescriber.
- ➔ The Epinephrine Self Carry Autoinjector Self Carry Agreement (reverse side of this form) must be completed.
- ➔ Non-prescription medication must be in the original packaging with the label intact and contain the student's name.
- ➔ The school nurse will call the prescriber, as allowed by HIPAA / FERPA, if a question arises about the child and/or child's medication.

PARENT / GUARDIAN AUTHORIZATION

I/We authorize designated school personnel to administer the medication as prescribed by the prescriber (below). I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that the ***medication must be in the original container*** and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate. I/We authorize the school nurse to communicate with the health care provider/prescriber or pharmacist to clarify the below listed medication order as allowed by HIPAA / FERPA.

Parent/Guardian Signature_____ Date _____

Contact Phone #1_____ Contact Phone #2 _____

PRESCRIBING PROVIDER'S AUTHORIZATION

(this section MUST be completed by the prescribing provider)

Diagnosed Allergies _____

Medication_____ Dose_____ Route_____

Date of medication to begin_____ Date of medication to end_____

* **Please note: orders only Valid for one school year** *

Specify here if student can self-carry and self-administer medication on school premises_____

Relevant side effects: None expected Specify_____

Special Instructions _____

Prescriber Name/ Title_____

Phone_____ Fax _____

Prescriber's Signature_____

(blank area above for provider's stamp)

Date_____

☐ RN (school) has reviewed this completed parent form and prescriber's orders, Sign_____Date _____

(see back of form)