Client Picture:

Year 20_____-20_______

AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE AUTO-INJECTOR

(Please complete both sides.)

This form must be completed by a PHYSICIAN/APN/PA and PARENT/ CLIENT ANNUALLY for any client requiring Epinephrine while on campus or at a Thrive-sponsored event.

Section I: To be completed by the Physician/Advanced Practice Nurse/Physician's Assistant:

Client Name: ______________________________ DOB: _________WEIGHT_______

ALLERGY TO: ____

Asthmatic Yes* ( ) No ( ) *Higher risk for severe reaction

Past history of symptoms of Anaphylaxis were:____

Or _____Unknown at this time but the client is at risk for future anaphylaxis.

Location of epinephrine (check all that apply): with client________ with nurse________ other________

DOSAGE:

Epinephrine: Inject IM (select one): _______Epinephrine auto-injector 0.3mg up to 2 doses PRN

______ Epinephrine auto-injector 0.15mg up to 2 doses PRN

Antihistamine: give____

Medication/dose/route

Other: give ____

Medication/dose/route

TREATMENT BY CLIENT (SELF-ADMINISTRATION) (Please check all that apply):

____This client has a potentially life-threatening allergy and will carry epinephrine at all times while on campus or when attending a Thrive sponsored event.

______This client understands, has been instructed, and is capable of the proper technique of self -administration of the prescribed medication(s).

_____ This client is aware that he/she must report any suspected exposure to allergen, any signs of allergic reaction, and any use of prescribed medication to a staff member immediately.

_____ The client will inform staff of potential allergen exposure.

Does the client require seating at an allergen free table? _____ Yes _____ No _____

Physician Signature: ____ Date: ______

Physician's Stamp

(Parent / C– Please complete Page 2)

SECTION II: TO BE COMPLETED BY PARENT/GUARDIAN/CLIENT

Emergency Contacts – Name/Relationship (List Parent/Guardian First) – Telephone Numbers

1. ______________________________ **(H)** _________________ © _________________ **(W)** ________________

2. ______________________________ **(H)** _________________ © ________________ **(W)** _________________

My child requires emergency administration of epinephrine by a pre-filled single- dose auto-injector mechanism containing

epinephrine in the event of anaphylaxis.

I consent to the following for the 20____/20____year:

- I will assure that the medication is in its original prescription container.
- I understand that it is my responsibility to ensure that _______________ has the medication available at Thrive at all times.
- I will be responsible for noting the expiration date and replacing expired medication.

  For clients allowed to carry and self-administer: Extra medication will be sent to Thrive to be kept in the Health Office in case my child forgets to bring the prescribed medication.
- I give permission for my child to receive medication at Thrive as prescribed by my child's physician.
- I give permission for the release and exchange of information between the nurse and my child's health care provider concerning my child's health and medications.
- I give permission for the nurse to share this medical information with members of the district staff who have direct responsibility for my child on campus or at a Thrive sponsored event.
- I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from the administration or self-administration of medication by the client and/or staff, and we, the parents or guardians, indemnify and hold harmless the HCESC Thrive and its employees or agents against any claims arising out of the administration or self-administration of medication by the client and/or staff. Any person who acts in good faith in accordance with the requirement of P.L. 2007, c 57 shall be immune from any civil or criminal liability arising from actions performed pursuant to that section.
- I will contact the nurse with any questions or changes in my child's health condition

Parent/Guardian Signature: ____ Date________________

Designation of Administration of Epinephrine

The Nurse may designate, in consultation with the Building Administrator, another employee of the district to administer a pre-filled single dose auto-injector mechanism containing epinephrine when the nurse is not physically present at the scene. The employee(s) will be trained using the "Training Protocols for the Implementation of Emergency Administration of Epinephrine" issued by the New Jersey Department of Education.

Delegates are assigned according to activity-sports, activities & trips.

(PLEASE CHECK ONE ANSWER)

______**I give consent** for a trained employee(s) of the district to administer epinephrine in the event the nurse is not present at the scene. I understand that the district and its employees or agents shall incur no liability as a result of any injury arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine, and that I indemnify and hold harmless the district and its employees or agents against any claims arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine.

______ I **do not consent** for an employee to be designated as an epinephrine delegate for my child.

Client Self Administration

______I allow my child to carry and self-administer epinephrine auto-injector

______I do not allow my child to carry and self-administer epinephrine auto-injector

Parent/Guardian Signature:____ Date:_________

Client Signature: ____ Date: ________