ROCKLAND PUBLIC SCHOOLS
ROCKLAND, MASSACHUSETTS

Physician and Parent/Guardian Authorization for Epinephrine Administration

(Doctor please check #1 or #2)

_____1.Administer the medication named below immediately **if stung** by a bee, wasp,hornet, etc.

_____2.Administer the medication named below immediately **if anaphylactic reaction** occurs.
i.e. food allergies or insect sting.
(Check here if allergy is unknown but is a possibility with this child.)

***** Transport immediately to hospital once medication has been administered, along with the used Epinephrine Kit.*****

NAME OF PATIENT_____DOB_____

ADDRESS_____

SCHOOL_____GRADE_____

MEDICATION_____

DOSAGE_____

SPECIFIC INSTRUCTIONS (if any)_____

POSSIBLE SIDE EFFECTS_____

PHYSICIAN'S SIGNATURE_____DATE_____

ADDRESS_____

****

TO BE COMPLETED BY PARENT:

I understand that school personnel are not responsible for any problem arising from the effects or the administration of this medication. I also understand that the School System cannot guarantee that every staff member will be ready, willing, and/or able to administer the epinephrine.

I understand that circumstances may make it necessary that I, or someone I find reliable, need to accompany my child on trips if a school representative is unable or unwilling to administer this medication away from the school.

I understand it is my responsibility to replenish or update the medication whenever it is necessary and to arrange for the medication to be left in the school nurse's office.

I further agree to indemnify and hold harmless the School System and its agents or servants against claims resulting from any and all acts performed under this authority since I recognize that the School System and its agents or servants are performing acts beyond that required by law. For its part, the School System and its agents or servants understand that all actions or omissions will be done in good faith.

SIGNATURE OF PARENT OR GUARDIAN_____DATE_____

PHONE_____

(df)6/01