Epinephrine Auto-Injector Medication Authorization

Ankeny Christian Academy
1604 W 1st St
Ankeny, IA 50023

Student Name _____ Date of Birth_____ Grade _____

Home Address _____ School Year _____

Healthcare Provider to Complete:

I verify this medication has been prescribed for above student in the event of signs or symptoms of an allergic reaction and/or suspected exposure to the following allergen(s): _____

Signs/Symptoms _____

Medication_____**Strength/Concentration**_____ **Dosage**_____

Route_____ Beginning Date _____ Expiration Date_____ or end of school year ☐

CALL 911 when medication is administered. Repeat dose if medication does not produce relief ☐yes ☐no

THIS SECTION IS ONLY FOR THE PERMISSION TO SELF CARRY: I provided the student with training in the use of an auto-injector and he/she has demonstrated its proper use. ☐ **yes** ☐ **no**

The student is capable of possessing and self-administering the auto-injector. ☐ **yes** ☐ **no**

I have prescribed a back-up auto-injector to be kept at school for as needed use by trained staff. ☐ **yes** ☐ **no**

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address _____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

I authorize the student named above to have access to and use the medication as ordered above and have read the ACA Student Handbook and medication policy.

I understand my student's epinephrine auto-injector will be stored in the school medication cabinet to ensure its availability

If my student is determined capable to self-carry and self-administer by myself, the healthcare provider and the school nurse, then I authorize my student to carry and use their epinephrine auto-injector as prescribed above, at school and school events: ☐ **yes** ☐ **no**

I will instruct my child to inform school staff if he/she has used the auto-injector so school staff can immediately call 911.

I understand that I should provide ACA with backup emergency medication to be kept at a location that is accessible at ACA.

I understand the medication must be in the original container and properly labeled. I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes. I understand emergency medical service (EMS) will be called if the epinephrine is used and I authorize pertinent information to be shared with EMS.

I authorize Ankeny Christian Academy staff to communicate with the student's health care provider as necessary.
I release and agree to hold ACA Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ Date _____