AUTHORIZATION TO ADMINISTER EPINEPHRINE
(To Be Completed by Physician or Advanced Practice Nurse)

Name of Student: _____ Grade: _____

The Student named above requires administration of epinephrine for anaphylaxis and does not have the capability to self-administer the medication.

Dosage: _____

Special Instructions: _____

Description of Emergency Situation: _____

Possible Side Effects: _____

_____ _____
Date Signature of Prescribing Physician

_____
Address

_____
Phone

PARENT / GUARDIAN AUTHORIZATION AND ACKNOWLEDGEMENT

I / We hereby authorize the School to administer epinephrine via EpiPen to the student named above, in accordance with New Jersey Law and the School policy stated below, as stated in the orders of the physician / advanced practice nurse above. This authorization includes the school nurse or, in the absence of the School nurse, another School employee designated and trained by the school nurse in accordance with New Jersey law.

I / We acknowledge receipt of written notice from the School that, provided the procedures set forth in New Jersey law and School policy are followed, the school and its employees or agents shall have no liability as a result of any injury arising from administration of the EpiPen to the Student. I / We understand and agree that the School and its employees or agents shall have no liability as stated in the written notice. I / We further agree to indemnify and hold harmless the School and its employees or agents against any claims arising out of administration of the EpiPen to the Student.

I / We understand this authorization and these agreements are **effective for the duration of the current school year**.

_____
Signature of Parent / Guardian

_____
Name of Parent / Guardian (PRINT)