Ohio Department of Health
Authorization for Student Possession and Use of an Epinephrine Autoinjector
In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent/Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief	

Possible severe adverse reactions

To the student for whom it is prescribed (that should be reported to the prescriber)
To a student for whom it is ***not*** prescribed who receives a dose
Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses

Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 1

(Parent/guardian signature required on Part 2). A completed form must be provided before the student may possess and use an epinephrine autoinjector to alleviate anaphylaxis in schools.

Student name A	❑ Male ❑ Female Date of birth	Student address	Student ID#	Student Photo (Must attach)
Grade/Class	Teacher	School	Height/Weight (optional)	

Medication order in this section must be signed by the licensed prescriber

Medication Name and Start/End Date	Dosage Route and Time Interval (Specify signs, symptoms or situations)	Possible Severe Adverse Reactions	Special Instructions (Choose all that are appropriate)
❑ See Allergy Action Plan 1 Extremely reactive to the following foods (allergen): _____ _____ _____ **1. Medication** ❑ EpiPen® Autoinjector ❑ EpiPen® Jr Autoinjector ❑ Other epinephrine autoinjector _____ _____ Diagnosis: _____ Begin Date: _____ End Date (if known): _____	**Time** 2 • If checked below, give ordered epinephrine immediately for ANY symptoms if the allergen was likely eaten. • If checked below, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted • Other _____ **Standard Order (Intramuscular or subcutaneously into the anterolateral aspect of the thigh) PRN for** ❑ **EpiPen®** 0.3 mg/0.3 ml, (2 ml) 1:1000 sterile solution, delivers 0.3 mg per injection ❑ May repeat in 15-20 minutes ❑ **EpiPen® Jr** 0.15 mg/0.3 ml, (2 ml) 1:2000 sterile solution, delivers 0.15 mg per injection ❑ May repeat in 15-20 minutes Note: EpiPen® & EpiPen JR® each contain 2mL epinephrine solutions. Approximately 1.7 mL remain in the autoinjector after use and cannot be reused. ❑ **Other epinephrine autoinjector medication** _____ ❑ Twin pak Dose _____ ❑ May repeat in 15-20 minutes 2. **Call 911** (per law if autoinjector used) 3. Begin monitoring	**Possible Severe Adverse Reactions per ORC 3313.718:** 3 ❑ To the student for whom it is prescribed (that should be reported to the physician) _____ _____ ❑ To the student for whom it is **NOT** prescribed who receives a dose _____ _____ ❑ Other _____ _____	**Special Instructions** 4 ❑ As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector. **(Parent must also sign Part 2)** ❑ Backup dose is ordered (parent will provide a backup dose of the medication to the school principal or nurse as required by law) ❑ **Procedures to follow if the medication does not produce the expected relief** _____ _____ ❑ **Procedures to follow if student is unable to administer anaphylaxis medication** _____ _____ ❑ Store medication in school health room and student to self-administer under observation ❑ Store medication in school health room and nurse or school staff to administer in emergency **Other** _____
2. Medication _____ Diagnosis: _____ Begin Date: _____ End Date (if known): _____	❑ **Standing Daily Dose** **Specify Time** _____ am **and/or** ❑ prn _____ **Time Interval** every (q) _____ hours as needed _____ _____ (specify signs, symptoms or situations)	**Possible Severe Adverse Reactions Reportable to Prescriber** _____ _____ _____	**Special Instructions** ❑ Store medication in school health room and nurse to administer ❑ Requires refrigeration ❑ Other _____ _____
3. Medication _____ Diagnosis _____ Begin Date _____ End Date (if known) _____	❑ **Standing Daily Dose** **Specify Time** _____ am **and/or** ❑ prn _____ **Time Interval** every (q) _____ hours as needed _____ _____ (specify signs, symptoms or situations)	**Possible Severe Adverse Reactions Reportable to Prescriber** _____ _____ _____	**Special Instructions** ❑ Store medication in school health room and nurse to administer ❑ Requires refrigeration ❑ Other _____ _____
List Home medication(s) _____ _____ 5 _____ _____ _____	**Prescriber** (please print) 6 _____ **Prescriber address** _____ _____	**Prescriber signature/date** 6 _____ **Prescriber Emergency phone** _____ **Fax** _____	**For Nurse Use Only: (Revision per Licensed Nurse after consultation with prescribing provider)** _____ _____

Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 2

Prescriber order(s) and signature required on Part 1. A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector in school to alleviate allergy symptoms

Student Information

A

Student name	Date of birth
Student address	Grade/Classroom

Parent/Guardian Authorization

B

- ☑ I authorize a designated employee of the school board to administer the prescribed medication as ordered for my child
- ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed
- ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist should a question come up about the medication
- ☑ Medication and medication form must be received by the principal, his/her designee or the school nurse
- ☑ I understand that the medication must be in the **original container** and be **properly labeled** with the student name, prescriber name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate
- ☑ By law, I agree that it is important to keep a back up epinephrine autoinjector at the school's designated location
- ☑ I understand I must to come into the school office/clinic when my child's medication is discontinued by the prescriber or at the end of the school year, or medication will be disposed of one week post-discontinuation orders or school year end

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone
		( )	( )

Self-Carry Authorization

C

Parent must ☑ below to indicate student is allowed to self-carry their epinephrine autoinjector

- ❑ I authorize and recommend self-medication by my child for the prescribed listed medication
- ❑ I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending prescriber

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone
		( )	( )

Do not write below (For school staff only)

D

Reviewed by	Title/Position	Date
Comments		

❑ File per district policy