EPINEPHRINE AUTO-INJECTOR PHYSICIAN ORDERS

Dear physician,

This form is being presented to you to request your orders for medical procedures. The student listed below will be attending SCA in the near future, and we are requiring your orders to do the procedures listed below. Please complete items 1 through 9, read the statement below, and fax or return orders to the school clinic. These medications must be supplied by the parent/guardian in their original container(s) from the pharmacy. This form is effective only for this school year and includes all school sponsored activities and summer programs.

Student Name _____Date of Birth_____

Grade_____ Sex ____ Teacher/First Period Teacher_____

1. What is the student Allergic to? _____

2. What are the signs and symptoms of the student's allergic reaction? _____

_____

3. The ***Epinephrine Auto-injector*** will be kept at the school (check one) in the clinic. _____ with the student._____

4. Is the student aware of this allergy and its possible seriousness? Yes _____ No _____

5. Has the student been instructed in the use of the ***Epinephrine Auto-injector***? Yes _____ No _____

6. Is ***Epinephrine Auto-injector to be used immediately***? Yes _____ No _____

If not, at what time after bite, sting, etc. should it be given? _____

What are the specific signs that signal the need for epinephrine? _____

7. Must the student carry the ***Epinephrine Auto-injector*** on their person? Yes _____ No _____

8. Will the student self-administer? Yes _____ No _____

9. Please list any other specific directions to be followed. _____

_____

I give my permission for school personnel to administer prescribed medication listed above. I agree to allow this information to be shared with adults responsible for my child's care. I understand that I am responsible for providing the school with the prescribed medication in the amount needed and in its original container with the label intact as needed by my child. I hereby release Seffner Christian Academy School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

Signature of Parent/Guardian: _____ Date_____

Printed Name of Parent/Guardian: _____ Phone: _____

Signature of Physician: _____ Date _____

Printed Name of Physician _____ Phone: _____ Fax: _____

Please fax the completed form to the Seffner Christian Academy school nurse at 813-627-0330