LIBERTY CHRISTIAN ACADEMY

Phone: 740-964-2211 Fax: 740-964-2311

Effective March 22, 2007, Ohio Senate Bill 164 permits students to carry and use an epinephrine auto-injector with the written approval of their parents and health care provider

PERMISSION TO CARRY AND SELF-ADMINISTER EPINEPHRINE AUTO-INJECTOR (EpiPen)

Parent to Complete

Purpose: To permit students to possess and use prescribed medications during school hours when regular attendance at school would be impossible without the medication.

Student Name

Address **Telephone**

Date of Birth **School** **Room #**

To the Parent or Guardian:
THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES OR USES PRESCRIBED MEDICATION IN SCHOOL; BOTH THE PARENT AND PHYSICIAN PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification on this card.
2. I will assume responsibility for the safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I authorize Liberty Christian Academy Health Services personnel to communicate with my child's health care provider as necessary concerning the use of this medication.
5. I understand Liberty Christian Academy, members of the board of education or school employees are not liable in damages in a civil action for injury, death, or loss to person or property arising from prohibiting a student to use an auto-injector because of the employee's good faith belief that the conditions set forth in ORC 3313.718 have not been satisfied, or for allowing the student to use the auto-injector if the conditions have been satisfied or from the use of the auto-injector by an unauthorized user.
6. I release and agree to hold the Liberty Christian Academy Board of Education, its officials, employees, and staff harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

As the Parent/Guardian of the above named student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event or program sponsored by, or in which the student's school is a participant. I will instruct my child to inform school personnel if he/she has used the auto-injector so that the school employee can immediately call 911. I will provide a backup dose of the medication to the principal or school nurse as required by law.

Signature of Parent or Guardian **Date**

Home Telephone **Work Telephone** **Cell Phone**

Emergency Contact Number(s):

_____ _____
(Telephone #) **(Name and relationship to student)**

_____ _____
(Telephone #) **(Name and relationship to student)**

Reverse side to be completed by Healthcare Provider Rev 03/2012 DB

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Physician to Complete

I verify that this medication must be taken by _____
(Student's Name)
_____, during school hours.
(Student Address)

(Medication) **(Dosage)** **(Route)**

Beginning date _____ **Expiration Date_____**

The following information must be completed by the Healthcare Provider prescribing the epinephrine auto-injector.

Circumstances in which the auto-injector should be used: (include allergies causing anaphylaxis).

Procedures to follow in the event that the student is unable to administer the anaphylaxis medication or the medication does not produce the expected relief from the student's anaphylaxis:

Adverse reactions that should be reported to the healthcare provider:

Adverse reactions for unauthorized user:

As the above named student's healthcare provider I have determined that the student is capable of possessing and using the auto-injector appropriately and I have provided the student with training in the proper use of the auto-injector. According to state law I have prescribed a back-up auto-injector to be kept by the school nurse or the designated employee to give medication when the school nurse is not in the school.

Healthcare Provider's Signature_____ Date_____

Healthcare Provider's Emergency Telephone Number_____

Healthcare Provider's Printed Name or official stamp:

Reverse side to be completed by Parent
Rev 03/2012 DB