FORM 7

EPIPEN®/TWINJECT® AUTHORIZATION

ARCHDIOCESE OF WASHINGTON – Catholic Schools

NOTE: THIS IS A RELEASE AND INDEMNIFICATION AGREEMENT AUTHORIZATING USE OF AN EPI-PEN or TWINJECT

PART I: TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ Sex: ◯ ◯ Birth Date: _____

Print Student's Name Male Female *mm/dd/yyyy*

School's Name: Saint Peter's School School Year: 2017-2018

Allergies: _____

PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here and in the Archdiocese of Washington Catholic Schools Policies and district or state guidelines.
2. **Schools do NOT provide medications for student use.**
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication Authorization forms are required for each Prescription and Over-The-Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days also require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form.**
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing Part II. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    - Student name
    - Date of Birth
    - Diagnosis
    - Signs or symptoms
    - Name of medication to be given in school
    - Exact dosage to be taken in school
    - Route of medication
    - Time and frequency to give medications, as well as exact time interval for additional dosages
    - Sequence in which two or more medications are to be administered
    - Common side effects
    - Duration of medication order or effective start and end dates
    - LHCP's name, signature and telephone number
    - Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and it's expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    - Name of student
    - Exact dosage to be taken in school
    - Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.

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PART I: TO BE COMPLETED BY PARENT/GUARDIAN (CONTINUED)

14. Students are NOT permitted to self medicate. The school does not assume responsibility for medication taken independently by the student. Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications, but those exceptions must be agreed upon and written in separate forms.

I hereby request designated Saint Peter's School **personnel to administer an epinephrine injection as directed by this authorization. I agree to release, indemnify, and hold harmless the Archdiocese of Washington, the parish, school personnel, employees, or agents from any lawsuit, claim, expense, demand or action, etc., against them for helping my child use this medication. I have read the procedures outlined above and assume responsibility as required. I am aware that the injection may be administered by a non-health professional.**

Name of Parent/Guardian: _____ Home Phone: ( ) -

Signature of Parent/Guardian: _____ Date: _____

PART II: TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER WITH NO ABBREVIATIONS

NOTE: **Emergency injections may be administered by non-health professionals. For this reason, only pre-measured does of epinephrine (auto injector) may be given. It should be noted that these staff members are not trained observers. They cannot observe for the development of symptoms before administering the injection.**

The following injection will be given immediately after report of exposure to _____

(Indicate specific allergens)

Route of Exposure: ☐ **Ingestion** ☐ **Skin Contact** ☐ **Inhalation** ☐ **Insect bite or sting**

Check ✓ appropriate boxes:

☐ **EpiPen** ☐ **Twinject 0.3**

☐ Give the pre-measured dose of 0.3 mg epinephrine 1:1000 (0.3cc) by auto injection, intramuscularly in anterolateral thigh.
☐ Repeat the dose in 15 minutes if EMS has not arrived (Two pre-measured doses will be needed in the school.)

☐ **EpiPen Jr.** ☐ **Twinject 0.15**

☐ Give the pre-measured dose of 0.15 mg epinephrine 1:2000 (0.3cc) by auto injection, intramuscularly in anterolateral thigh.
☐ Repeat the dose in 15 minutes if EMS has not arrived (Two pre-measured doses will be needed in the school.)

Common Side Effects: _____

Effective Date: Start _____ End _____ If student is taking more than one medication at school, list sequence in which medications are to be taken: _____

Check ✓ appropriate boxes:

☐ **I believe that this student has received adequate information on how and when to use an Auto injector, has demonstrated its proper use, and has the capacity to use the injector in an emergency.**

a. The student is to carry an Auto injector during school hours with principal approval.
b. The student can use the Auto injector properly in an emergency
c. One additional dose, to be used as backup, should be kept in clinic or other designated location in the school.

☐ The Auto injector will be kept in the school clinic or other school approved location: _____

☐ Allergy Action Plan for the aforementioned student is attached.

Licensed Healthcare Provider: _____ Phone: ( ) -

Signature of LHCP: _____ Date _____

Parent/Guardian: _____ Phone: ( ) -

Signature of Parent/Guardian: _____ Date _____

Signature of Student (Required if student carries Auto injector) _____

PART III: TO BE COMPLETED BY PRINCIPAL OR REGISTERED NURSE

Check ✓ as appropriate:

☐ Parts I and II above are completed including signatures. (It is acceptable if Part II is written on the LHCP stationery or a prescription pad).

☐ Auto Injector is appropriately labeled. _____Date by which any unused medication is to be collected by the parent (Within one week after expiration or on the last day of school)

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Signature of Principal/Nurse: _____ Date _____

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