Granite Falls School District

AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE AUTO-INJECTOR/MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL (LHP) PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

(Please clearly print legible instructions)

STUDENT ALLERGIES**:** _____

Known Triggers: ◯ Ingestion ◯ Touch ◯ Sting ◯ other (list): _____

EPINEPHRINE AUTO-INJECTOR ORDER

Dose: (Circle one) 0.15 mg 0.30 mg

Student is able to self-administer: YES NO
Student may carry auto-injector on self: YES NO
This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.
Possible Side Effects:
_____

ORAL MEDICATION ORDER

Medication:_____
Dose: _____
Frequency: _____
Student is able to self-administer: YES NO
Student may carry their medication: YES NO
This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.
Possible Side Effects:
_____

ADMINISTRATION CHOICES (please check all that apply):

Give Auto-Injector Epinephrine for known or possible ◯ Ingestion ◯ Touch ◯ Sting of: _____.
Specify the minimum length of time between doses of epinephrine auto-injector: _____

Administer _____ (oral medication) for known or possible ingestion/touch/sting/other (list) _____.
____ If student develops hives, rash, itchy mouth or other symptom(s) (list) _____
____ After Epinephrine Auto-injector is given

I request and authorize the above-named student to be administered the above identified medication in accordance with the instructions indicated above valid for current school year including summer school unless otherwise indicated. **(not to exceed current school year).**
There exists a valid health reason which may make administration of the medication advisable during school hours.

_____ _____
Date of Signature Licensed Health Professional (LHP)

_____ _____
Telephone Number Name (please print)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- I request this medication to be given as ordered by the licensed health professional.
- I give Health Services Staff permission to communicate with the medical office about this medication. I understand oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- Medication information may be shared with school staff working with my child and 911 staff, if they are called.
- All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health professional.
- I request and authorize my child to carry and/or self-administer their medication. ____ Yes ____ No

_____ _____
Date of Signature Parent/Guardian Signature
Telephone numbers: _____ (home) _____ (work) _____ (cell)

Reviewed by Registered Nurse: _____ Date: _____