pace
Learning Redefined

2432 Greensburg Pike,
Pittsburgh, PA 15221

Phone 412.244.1900
Fax 412-244-1902

Health Office Phone 412-342-4317
www.paceschool.org

AUTHORIZATION FOR ADMINISTRATION OF AN EPINEPHRINE AUTO-INJECTOR

Effective July 1 to June 30 of the current school year

Student Name: _____ D.O.B.: ___/___/____

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

Licensed Health Care Provider's Name: _____ Ph: _____

Address: _____ Fax: _____

Diagnosis: _____

Medication: _____ Strength: _____ Dose: _____

Form: Auto-injector device

Time of Administration: **PRN for the signs and symptoms of a life threatening allergic reaction**

How soon can a second dose of the medication be administered: _____

911 WILL BE CALLED IMMEDIATELY AFTER THE ADMINISTRATION OF THE FIRST DOSE AND THE STUDENT WILL BE TRANSPORTED TO AN APPROPRIATE MEDICAL FACILITY.

Indications for medication administration: Wheezing Shortness of Breath Coughing Chest Tightness

Difficulty swallowing Swelling of the face, lips tongue Loss of Consciousness (PLEASE CIRCLE ALL THAT APPLY)

Other indications: _____

The medication cannot be repeated more than: _____

Side Effects: _____

Comments: _____

Is the child knowledgeable about his/her emergency medication: **YES** **NO**

Has the child demonstrated the proper technique to administer the medication: **YES** **NO**

It is my professional opinion that _____ **SHOULD NOT BE PERMITTED TO CARRY** and/or self-administer the epinephrine auto-injector.

Licensed Health Care Provider's Signature: _____ Date: ___/___/____

FOR COMPLETION BY PARENT/LEGAL GUARDIAN

I, _____, **DO NOT GIVE PERMISSION** for my child to carry and
(Print Parent/Legal Guardian Name)

self-administer the epinephrine auto-injector prescribed by his/her licensed health care provider. I hereby authorized the appropriate staff person at Pace School to administer the epinephrine auto-injector during school hours if my child begins to display the signs and symptoms of a life threatening allergic reaction. I also understand my child will be transported to the appropriate medical facility and I will be notified as soon as possible by the nurse or an administrator at Pace School. This consent is only for the current school year.

Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Student Signature (if 14 years of age or older): _____ Date: _____/_____/_____

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ORAL AUTHORIZATION – NOT APPLICABLE TO HIV RELATED INFORMATION

I witness that the person understood the nature of this consent and freely gave his/her oral authorization.
(Two witnesses are required)

Name of person giving oral authorization: _____

Relationship: _____ **Date:** _____

Witness #1: _____ **Date:** _____

Witness #2: _____ **Date:** _____

The Parent/Legal Guardian was informed that a two person verbal consent may be obtained by the nurses initially to administer medications but the Parent/Legal Guardian are still required to sign the Permission to Administer Medication During School Hours form as soon as possible.