Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141
A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

The following section must be completed by the PARENT/GUARDIAN:

<table>
<thead>
<tr>
<th>School:</th>
<th>Grade:</th>
<th>Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student’s Last Name:</td>
<td>First Name:</td>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

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I have read and understand the Mayfield City School guidelines for giving medications. As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event or program sponsored by or in which the student’s school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. **I will provide a back-up** dose of the medication to the school principal or nurse as required by law.

____/____/____ ____________________________________ (______) __________________ (______) ______________

Date Parent/Guardian Signature Home/Cell Phone Emergency Phone

The following section must be completed by the LICENSED PRESCRIBER:

| Name and Dosage of Medication: |
| Date Medication Administration Begins: | Date Medication Administration Ends (if known): |
| Circumstance for use of the epinephrine autoinjector: |
| Procedures for school employees if the student is unable to administer the medication or if it does not produce expected relief: |

**Possible Side Effects:** To the Student for Which it is Prescribed (that should be reported to physician):

**Possible Side Effects:** To a Student for Which it is NOT Prescribed Who Receives a Dose:

Special Instructions:

(Licensed Prescriber’s Stamp) Licensed Prescriber’s Printed Name:

_________________________________________________

Licensed Prescriber’s Signature:

_________________________________________________

Date: _____/_____/_______ Telephone Number: (_____) __________________

Rev 2/23 Adapted from the Ohio Association of School Nurse HEA 4222 3/07

***Please note a new form is required for every school year

SCHOOL FAX NUMBERS

High School Fax: 440-995-6805  Gates Mills Fax: 440-995-7505  Preschool Fax: 440-995-6805
Middle School Fax: 440-449-1413  Lander Fax: 440-995-7355  CEVEC Fax: 440-646-1117
Center Fax: 440-995-7405  Millridge Fax: 440-995-7255  EXCEL TECC Fax: 440-995-6755