Side A

Williamsport Area School District
Division of Student Services
Department of School Health Services

PHYSICIAN'S ORDER FOR EPINEPHRINE AUTO-INJECTOR

Name of Student: _____

DOB: _____

Allergies: _____

Medication	Strength	Dosage	Time to be Given	Route of Administration	Duration of Order

Reason medication is needed: _____

Possible Side Effects: _____

_____

☐ Child is knowledgeable about this medication and how to administer it.

☐ Child may carry Epinephrine Auto-Injector and self administer medication.

_____ _____

Physician's Name – **PRINTED** Physician's Signature

_____ _____

Phone Date

08/2024

(OVER ☞)

Side B

PARENTAL AUTHORIZATION AND INDEMNIFICATION FOR THE DISPENSATION OF EPINEPHRINE AUTO-INJECTOR

I, _____, parent or legal guardian of
(name of parent)

_____, hereby authorize the Williamsport Area School
(name of student)
District and its nurses and/or designated employees to permit my child to carry and to self administer his/her Epinephrine Auto-Injector. Prescription medicine will be accompanied by the prescribing physician's instructions.

I agree that the District and its employees are not to be held liable for allowing self-administration of Epinephrine Auto-Injector medicine in accordance with this Authorization. I agree to hold harmless and indemnify the Williamsport Area School District and all of its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action that may be brought against the District or its employees in connection with permitting self-administration. I acknowledge that the District and its employees bear no responsibility for ensuring that the medication is taken as prescribed.

This Authorization shall be effective unless revoked by me in writing. I intend to be legally bound by this Authorization. This authorization and the accompanying prescription must be renewed for each school year.

I understand that failure to adhere to the Epinephrine Auto-Injector policy will result in a loss of privilege to carry Epinephrine Auto-Injector for the remainder of the current school year (and subsequent disciplinary action).

_____
Date Signature of Parent and/or Guardian

Permission

I, _____, give permission for the school nurse or
(name of parent)
Health Room Technician to contact Dr. _____ to discuss the medication that has been prescribed for my child. This permission will be considered valid for one year from the date signed. This permission may be revoked by written request at any time.

_____
Signature of Parent and/or Guardian

_____
Date