

HANOVER TOWNSHIP PUBLIC SCHOOLS

Emergency Administration of Epinephrine

PARENTS' /GUARDIANS' AUTHORIZATION

Pupil's Name	Date of Birth	Grade
Allergic Condition		

Parents'/Guardians' Statement

1. In the event that our child, named above, experiences potentially life-threatening symptoms related to his/her allergic condition as described by his/her physician, we authorize the emergency administration of epinephrine by a pre-filled auto-injector by the school nurse, and in her absence by a registered nurse, or an employee designated by the school nurse in consultation with the Hanover Township Board of Education who is properly trained in the administration of epinephrine auto-injection to our child.
2. We acknowledge our understanding that if the procedures for the emergency administration of epinephrine are followed, the Hanover Township Board of Education, collectively and individually, as well as its employees and agents, shall have no liability as a result of any injury arising from the administration of epinephrine to our child.
3. We indemnify and hold harmless the Hanover Township Board of Education, collectively and individually, as well as its employees and agents against any claims arising out of the emergency administration of epinephrine to our child.
4. We understand that our child will be transported to the hospital Emergency Room after the administration of epinephrine even if the child's symptoms have resolved.
5. We understand that the School Nurse will be available during school hours and may be available at school-sponsored events in case of an allergic reaction. The trained designee will be available during school hours and at school-sponsored events. We realize that it is our responsibility to inform the nurse in a timely manner of the school-sponsored events in which our child will participate.
6. Permission for the emergency administration of epinephrine to our child is granted for the _____ school year.
7. We agree to have _____ trained as the epinephrine designee and understand that the designee, by law, cannot administer any other medication
8. As Parent/Guardian of the above named student I hereby authorize the release of pertinent medial information to be exchanged among appropriate professional staff involved in the care of my child. This consent is valid for the school year and is intended to allow the staff to better serve my child.
9. I have read the Emergency Health Care Plan for my child and give my permission for its implementation.

Signature of Parent/Guardian/Date

Signature of Parent/Guardian/Date

