EAST WINDSOR REGIONAL SCHOOL DISTRICT

Division Of School Health Services
Hightstown, New Jersey

ANAPHYLAXIS INJECTION AUTHORIZATION

Authorization for the administration of epinephrine for anaphylaxis via pre-filled auto-injector mechanism

As the parent/guardian of_____ I hereby authorize the administration of
(Please print student's name)
medication for anaphylaxis via pre-filled epinephrine injection. If the nurse is not physically present at the scene, I give permission for the administration of the medication for anaphylaxis via pre-filled auto injector mechanism by an individual designated by the school nurse, who has been trained by the school nurse, using the standardized training protocols established by the Department of Education in consultation with the Department of Health and Senior Services.

I understand that the district will have no liability as a result of any injury arising from the administration of the epinephrine via a pre filled auto-injector mechanism to the pupil and that I indemnify and hold harmless the district and its employees and agents against any claims arising out of the administration of epinephrine via pre-filled auto-injector mechanism to the pupil.

Name of Parent/Guardian (please print)	Signature of Parent/Guardian	Date

Physician's Authorization

I certify that _____ is being treated by me for _____ which requires the administration of epinephrine for anaphylaxis.

Name of Physician (please print)	Physician's Signature	Date

Nurse's Approval

Nurse's Signature	Date	

Principal's Approval

I have reviewed the information submitted by you and your child's physician to have the school nurse or in her absence her trained designee, administer epinephrine via pre-filled auto-injector mechanism to your child. Your request is granted for the _____ - _____school year. Please be aware that in accordance with N.J.S.A. 18A 40-12.6, the district and its employees or agents shall incur no liability as a result of any injury arising from the administration of this medication. If you have any questions please contact the school nurse.

Principal's name (please print)	Principal's Signature	Date

Note: This form must be completed in addition to the standard medication form required of any student needing medication during school hours/activities, including class trips.