

**GLOUCESTER COUNTY SPECIAL SERVICES SCHOOL DISTRICT  
PERMISSION FOR EMERGENCY ADMINISTRATION OF EPINEPHRINE**

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THIS ORDER MUST BE RETURNED IN ITS ORIGINAL FORM. FAXES AND COPIES WILL NOT BE ACCEPTED.

, the parent/guardian of \_\_\_\_\_ authorize my child, a pupil at \_\_\_\_\_  
(Name of Student) (Nonpublic School)

School to be administered a pre-filled, single dose auto-injector mechanism containing epinephrine (provided by me) prescribed by our physician/or nurse practitioner as described below for anaphylaxis since he/she has a documented history of anaphylaxis and does not have the capability for self-administration of the medication.

\_\_\_\_\_ has been designated to administer a pre-filled, single dose auto-injector  
(Name of Designee)

mechanism containing epinephrine for anaphylaxis to my child. The designee has been properly trained by the school nurse using the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate Trained by the School Nurse" established by the Department of Education in consultation with the Department of Health and Senior Services.\*

I understand that this permission is valid only for this school year and must be renewed for each school year, should my child's condition require it. I further understand that neither the GCSSSD Board of Education, any district employee, chief school administrator of a nonpublic school, nor nonpublic school employee shall be responsible for any liability as a result of any injury arising from the procedures utilized for emergency administration of epinephrine to my child and that I shall indemnify and hold harmless the district or nonpublic school and its employees or agents against any claims arising out of the administration of a pre-filled, single dose auto-injector mechanism containing epinephrine to my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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**PHYSICIAN'S/OR NURSE PRACTITIONER'S AUTHORIZATION/ASSURANCE STATEMENT FOR  
EMERGENCY ADMINISTRATION OF EPINEPHRINE**

I certify that \_\_\_\_\_ is under my care for \_\_\_\_\_, a life-threatening condition and has a documented history of anaphylaxis. I am recommending that the above named student be administered a pre-filled, single dose auto-injector mechanism containing epinephrine for anaphylaxis since he/she does not have the capability for self-administration of the medication.\*

Name and purpose of medication: \_\_\_\_\_

Indications for emergency administration of epinephrine (specific signs and symptoms): \_\_\_\_\_

Identification of chronic medical problems: \_\_\_\_\_

Prescribed dosage and schedule: \_\_\_\_\_

Length of time medication be taken: \_\_\_\_\_

Possible side effects and/or special precautions: \_\_\_\_\_

\_\_\_\_\_  
Prescribing Physician's/Nurse Practitioner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PLEASE PRINT NAME AND ADDRESS OF PRESCRIBING PHYSICIAN

\_\_\_\_\_  
TELEPHONE #

\* Please note: The training of a designee and/or the physician's order for a medication does not guarantee the school nurse or designee will be available during all school hours.