BOB JONES ACADEMY

Rev 6/2024

Anaphylaxis Self-Administration Authorization Form

THIS FORM MUST BE FILLED OUT BY A LICENSED HEALTH CARE PROVIDER ONLY — PLEASE PRINT	
Student's Legal Name:	**Date of Birth:**

List Allergies:

Prescribed epinephrine type: Auto-injector	**Prescribed epinephrine dose:** ☐ **0.15 mg** ☐ **0.3 mg**	**Prescribed route:** Intramuscular
Prescribed antihistamine:	**Prescribed antihistamine dose:** _____ **For liquids concentration=_____mg/_____ml Dose=_____ml**	**Prescribed route:** Oral

Specific instructions for medication administration (For example, give diphenhydramine prior to epinephrine):

Symptoms may start as: (check all that apply)

- ☐ Itching and swelling of the lips, tongue or mouth.
- ☐ Itching and/or sense of tightness in the throat, hoarseness and hacking cough.
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea.
- ☐ Hives, itchy rash and/or swelling around the face or extremities.
- ☐ Shortness of breath, repetitive coughing and/or wheezing.
- ☐ Thready pulse or passing out.
- ☐ Other_____

The student has permission to self-carry/self-administer this medication: ☐ **No** ☐ **Yes — if yes, read the following carefully:**

If yes box is checked, I agree that this student must be allowed to have the above-named medication/procedure on his/her person during school hours, in transit to and from school-sponsored activities, before and after-school activities on school property, and any school-sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school responsible for any adverse outcome of this action.

Printed Name of Health Care Provider:_____ Phone:_____

Health Care Provider Signature:_____ **Date:**_____

Parents/Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following:*

- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the school nurse(s), and/or designated staff to share this information with individuals who have responsibility for my child.
- I give the school nurse my permission to contact the prescribing Licensed Healthcare Provider and prescribing pharmacy in relation to this prescription medication.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BJA staff to administer this medication to my child according to school policies.

My student has orders from our health care provider to Self-Carry/Self-Administer this medication:
☐ **No** ☐**Yes** ****If yes, read the following carefully:***

*Working closely with our physician we have decided to allow my child to self-administer and self-monitor the above medication while at school. **My child has been trained by our physician and has demonstrated competency in this procedure.** My child must be allowed to possess this medication at school sponsored activities, in transit to and from school-sponsored activities and before and after school activities on school property. I realize that Bob Jones Academy cannot be held responsible for an adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with my child's name. I will notify the school immediately if the medication is discontinued or the dosage has been changed. Permission is granted to the school nurse and/or designated staff to share this information with individuals who have responsibility for my child. The first dosage will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child.

Parent/Legal Guardian Printed Name:_____ Daytime Phone Number:_____

Parent/Legal Guardian Signature:_____ **Date:**_____

This form is only valid if signed on or after July 1st for the upcoming school year.