BOB JONES ACADEMY

Anaphylaxis Self-Administration Authorization Form

(For **High School** use only)

THIS SECTION TO BE FILLED OUT BY A *LICENSED HEALTH CARE PROVIDER* — PLEASE PRINT

Student's Legal Name:	**Date of Birth:**

Allergies:

Prescribed epinephrine type:	**Prescribed epinephrine dose:** ☐ **0.3 mg** ☐ **2 mg**	**Prescribed route:** ☐ IM ☐ nasal
Prescribed antihistamine:	**Prescribed antihistamine dose:** _____ **For liquids concentration=_____mg/_____ml Dose=_____ml**	**Prescribed route:** Oral

Specific instructions for medication administration (i.e. 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 it is appropriate for this student to have the above-named medication on his/her person. I agree that this child has demonstrated competency in self-monitoring and self-administration of this medication.

Printed Name of Health Care Provider:_____ Phone:_____

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

THIS SECTION TO BE SIGNED BY *PARENT/LEGAL GUARDIAN*-

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, clearly labeled with my child's name
- I will notify the school if the medication is discontinued or the dosage changes.
- I give permission to 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 if needed.
- Working closely with our physician, I agree to allow my child to self-administer and self-monitor the above medication while at school.
- **I agree that my child has been trained by our physician and has demonstrated competency.**
- I understand my child is 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.

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. Revised 7/2026