IVYMOUNT SCHOOL
EMERGENCY CARE FOR THE MANAGEMENT OF A STUDENT WITH A DIAGNOSIS OF ANAPHYLAXIS
Release and Indemnification Agreement for EpiPen® (Epinephrine Auto Injector)

PART 1- TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize Ivymount School personnel to administer an Epinephrine Auto Injector as directed by the physician (Part II, below). I agree to release, indemnify, and hold harmless Ivymount School and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided Ivymount School staff are following the physician's order as written in Part II below. I am aware that the injection may be administered by a trained unlicensed staff member. I have read the procedures outlined on the back of this form and assume the responsibilities as required.
I understand that the rescue squad (911) will always be called when an Epinephrine Auto Injector is administered, whether or not the student manifests any symptoms of anaphylaxis.

Student Name:____ Birth Date: ____/____/____

______________________________ ____-____-____ ____/____/____
Parent/Guardian Signature *Phone Number* *Date*

PART II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

In accordance with Maryland State Regulations, the Epinephrine Auto Injector may be administered by unlicensed Ivymount School staff that are trained by the school nurses. Unlicensed staff are not allowed to wait for the appearance and observe for the development of symptoms before administering the Epinephrine Auto Injector.

1. Name of Medication: Epinephrine Auto Injector (brand names include Epipen and Twinjet)
   - Ana-Kit® will not be accepted for use at school.
   - Epinephrine Auto Injector will not be accepted for the management of asthma.
2. Reason for medication: For the management of acute allergic reactions to: Check (✓):

☐ Stinging insects (bees, wasps, hornets, yellow jackets)

☐ Ingestion of (specify):____

☐ Other allergen(s) (specify under what circumstances):________________________________

3. Medication is to be given: Check (✓):

☐ If insect stings (bees, wasps, hornets, yellow jackets)

☐ Ingestion of (specify):____

☐ If other known or unknown allergen(s) (explain):________________________________

4. Route of administration for Epinephrine Auto Injector: Intramuscularly (IM) into anterolateral aspect of the thigh.
5. Dosage of medication: Check (✓) one: ☐ Epinephrine Auto Injector 0.15 mg. ☐ Epinephrine Auto Injector 0.3 mg.
6. Repeat dose in 10 minutes if rescue squad has not arrived.* ☐Yes ☐No OR ☐Other________________
   *NOTE: For repeat dose, a second Epinephrine Auto Injector must be ordered and brought to school
7. Side effects: Palpitations, rapid heart rate, sweating, nausea and vomiting

Health Care Provider________________________ ____ ____-______ ________________________ ____/____/____
Name-Print or Type Phone Number Signature Date

THIS PARENT MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR

TEACHER-CARRY/TEACHER-ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Teacher-carry/teacher-administration of student's **emergency** medication **must** be authorized by the parent and be approved by the school nurse according to the Ivymount School medication policy.

Parent's authorization for teacher-carry/teacher-administration of student's emergency medication________________________ ____/____/____
Signature, Parent/Guardian *Date*

School RN approval for teacher-carry/teacher-administration of student's emergency medication________________________ ____/____/____
Signature, School RN *Date*

PART III: TO BE COMPLETED BY THE PRINCIPAL OR SCHOOL NURSE

☐ Parts I and II are completed including signatures. It is acceptable if all items in Part II are written on the health care provider's stationery/prescription blank.

☐ Medication properly labeled by a pharmacist. Epinephrine Auto Injector received: ☐ 1 device ☐ 2 devices

Reviewed by: ________________________________ ____/____/____
Signature, Principal/School Nurse *Date*