Written Authorization for Self-Administration of EpiPen®/Auvi-Q by Minor Children at St. Catherine of Siena (Trumbull, CT) Religious Education Program ("Program")

Student Name: _____ Date of Birth: _____ Grade: ____

I, _____, Parent/Legal Guardian of the above-named student hereby request authorization for self-administration and possession of EpiPen® or other epinephrine auto-injectors by this student while in religious education class or at a religious education-sponsored activity. The student demonstrates full understanding of the proper use of his/her epinephrine device. I understand that the Program and its employees and agents shall incur no liability for:

a) any injury to the student caused by his/her self-administration of medication;
b) the student's use, misuse, overuse, or neglected or failed use of his/her allergy epinephrine device; and
c) lost, misplaced, outdated, inaccessible, empty, or faulty allergy medication and epinephrine devices.

I take sole responsibility for the monitoring of the epinephrine device, medication use, and refilling of prescriptions for the epinephrine device, for ensuring the student always carries his/her epinephrine device on his/her person, for informing Program staff in writing of any changes in the student's treatment or allergy management, and for informing the Program of any new or changed student medical information. I understand and agree to the conditions of the Program policy.

I permit the Program to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the epinephrine device be misused or given or taken by a person other than the above-named student. I release the Program and its employees and agents of any legal responsibility related to the above-named student's possession and self-administration of his/ her allergy epinephrine device.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Parent/Legal Guardian Print Name Date

I, _____, the above-named student have been instructed in the proper use of my prescription epinephrine device and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my epinephrine device under any circumstance. I understand and agree to the terms of the school policy.

_____ _____
Student's Signature Date

The above-named student has been instructed and demonstrates understanding of the proper use of his/her allergy epinephrine device. It is my professional opinion that the student be permitted to carry and self-administer his/her allergy epinephrine device. I have provided the parent/guardian with a written allergy emergency/management plan including the name, purpose, dosage, and administration directions of the epinephrine device.

_____ _____
Healthcare Provider Signature Date

_____
Print Name and Office Address