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:
l,, Paren	nt/Legal Guardian of the above-named stude	ent hereby request authorization for
self-administration and possession of education class or at a religious educ	f EpiPen® or other epinephrine auto-injecto ation-sponsored activity. The student demo evice. I understand that the Program and its	rs by this student while in religious instrates full understanding of the
a) any injury to the student c	aused by his/her self-administration of med	lication;
•	overuse, or neglected or failed use of his/he inaccessible, empty, or faulty allergy medical	
the epinephrine device, for ensuring informing Program staff in writing of	itoring of the epinephrine device, medication the student always carries his/her epinephrany changes in the student's treatment or a student medical information. I understand a	ine device on his/her person, for allergy management, and for informing
accept legal responsibility should the named student. I release the Progran	ency medical treatment for the student when e epinephrine device be misused or given or m and its employees and agents of any legal -administration of his/ her allergy epinephri	taken by a person other than the above responsibility related to the above-
Parent/Legal Guardian Signature	Date	
Parent/Legal Guardian Print Name	Date	
epinephrine device and fully understa	ove-named student have been instructed in and how and when to use this medication. In to use my epinephrine device under any c	will always carry my medication with
 Student's Signature	Date	
epinephrine device. It is my professionallergy epinephrine device. I have pr	instructed and demonstrates understanding onal opinion that the student be permitted to ovided the parent/guardian with a written as, and administration directions of the epine	o carry and self-administer his/her allergy emergency/management plan
Healthcare Provider Signature	Date	
Print Name and Office Address		