MOLALLA RIVER

AUTHORIZATION FOR EMERGENCY EPINEPRHINE

Student Name:	DOB:

As the parent or guardian of the above referenced student, I request that my child receive the following specialized health services: *Response to severe allergic reaction including administration of emergency epinephrine per MD orders and nursing protocol.*

Medication: Epinephrine Auto-injector
Dose: ☐ .15 mg (junior) ☐ .30 mg (regular)
Route: Intramuscular injections
For: Symptoms compatible with severe allergic reaction per physician's orders

I understand that:

- Administration of epinephrine is done only by designated persons who have completed the Severe Allergic Reaction training as per ORS 433.8433.800-830 and received specific training from a Registered Nurse as per OAR 851-047-0040.
- The prescription label must read **"Administer immediately upon signs of anaphylaxis" or "Administer immediately upon exposure to allergen"** or written orders must be provided by an **Oregon** licensed physician.
- By signing this form, I authorize the exchange of information between the district nurse, school personnel and my child's health care provider for the purposes of allergy management in the school setting.
- This authorization is valid for one year beyond the signed date.
- I am responsible to bring all necessary supplies and medications to school for my student and any medications not picked up by the last day of school will be disposed of.
- Use of antihistamines for severe allergic reaction require a written order from a provider.

Signature of parent Date