EPI-PEN INSTRUCTIONS

The Diocese of St. Augustine requires that the attached forms be on file in the school office for children with inhalers that are used at school. Please note the following:

1. Both the Medication Authorization form and the Epi-Pen form should be completed in their entirety and signed by parent and physician. **Please ensure that the physician indicates the dosage of the allergy medication on the forms, if allergy medication is indicated as part of the treatment plan.**

2. We are unable to administer the medication in the event your child needs it, if these forms have not been properly completed, signed, and submitted to the office.

3. Please provide two sets of both the Epi-Pen and allergy medication (if prescribed as part of the treatment plan), as we keep one set in the school clinic and provide one set to the PE teacher. (PE classes are held at the social hall or on the fields, both of which are a good distance from the school if an emergency situation arose that required the administration of the Epi-Pen.)

4. You are required to submit new forms every school year.

5. Please ensure that medication that is provided to the school is not close to or past its expiration date, as we will be unable to administer the medication if the expiration date has passed.

Medical Authorization

The following section is to be completed by the **PARENT/GUARDIAN** for the administration of medication. Medications must be in original containers.

Child's Name: _____ _____ _____
Last First Sex Date of Birth

_____ _____ (____) _____
Physician's Name Address Telephone

I deliver the medicine(s) described below to ***Name of School*** *to be held for use by my child in accordance with the instructions given below. I consent and authorize the person designated by the School to dispense and to supervise my child's self-administering the medicine(s). We/I understand that the School assumes no responsibility for the instructions we/I have provided below, other than to allow my child to self-administer the medicine(s) and we/I assume all risk associated with the child's taking such medicine(s).*

We/I understand that under the provision of Florida Statute 232.46, school personnel cannot be held liable for reactions or side effects from the administration of the medication(s). We/I also grant permission for school personnel to contact the physician if there are questions or concerns about the medication(s).

_____ (____)_____ (____)_____
Date ***PARENT/GUARDIAN*** Signature Home Phone Emergency Phone

The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: _____

Name of Medicine _____

Form _____

Dose _____

If medicine is to be given DAILY, at what time? _____

If medicine to be given "WHEN NEEDED," describe indications: _____

_____

How soon can it be repeated? _____

Is child authorized to medicate herself/himself? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Other information: _____

_____ _____
Date Physician Signature

RELEASE AND WAIVER OF LIABILITY REGARDING CHILDREN WITH SEVERE MEDICAL CONDITIONS AND ADMINISTRATION OF EPINEPHRINE

[Including, but not limited to allergies, asthma, and seizure disorders]

This is a RELEASE AND WAIVER OF LIABILITY REGARDING CHILDREN WITH SEVERE MEDICAL

CONDITIONS (hereafter, referred to as the "Release") made the _____ day of _____, 20____ by and

between _____ School, Bishop Felipe J. Estevez, as Bishop of the Diocese of St. Augustine, a corporation sole, and individually, (hereinafter, collectively referred to as the "School"), and their agents and employees and _____ residing at _____
(Parent(s)/Guardian(s)

_____, who are the Parent(s)/Guardian(s) of

_____.
(Child's Name)

The School has been authorized to administer medical treatment, (including the administration of Epinephrine) to the child during certain situations when a medical emergency, as described in the child's authorization for administering medical treatment and/or the child's physician's treatment plan for children with seizures.

In consideration of the agreements and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. Parent(s)/Guardian(s) hereby release and forever discharge the School, its employees and agents from any and all liability arising in law or equity as a result of employees or agents including specifically, but not limited to the child's teacher, administering epinephrine or providing any medical treatment to the child relating to such medical conditions.
2. This Release shall be governed by the laws of the State of Florida, which is the location of the School in which the child is enrolled, excluding its choice of law provisions.
3. This Release supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning all subject matters covered herein. This instrument, along with the Authorization (including any additional Physicians' instructions or clarifications), which is hereby incorporated by reference, constitutes the entire agreement among the parties with respect to the subject matters discussed herein.
4. The reference in this Release to the term "the School" shall include the Diocese of St. Augustine, and their affiliates, successors, religious directors, officers, employees, agents and representatives. The terms Parent(s)/Guardian(s) shall include the dependents, heirs, executors, administrators, assigns and successors of each.
5. If any staff member determines that administration of an injection of medication provided by the Parent(s)/Guardian(s) or any other measure is necessary the School shall be held harmless from any and all liability as a result of such action and the outcome of such administration or measure.
6. This Release also shall constitute an estoppel against any and all legal or equitable claims and the Parent(s)/Guardian(s) shall further hold harmless and indemnify the School in the event any claim is asserted by any third party against the parties covered by this agreement. The indemnification includes all cost and attorney's fees incurred by the School.
7. If one or more of the provisions of this Release shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect or impair any other provision of the Release. This Release shall be construed as if such invalid, illegal or unenforceable provisions had not been contained herein.

School Witness	Parent/Guardian
_____ Signature	_____ Signature
_____ Print Name	_____ Print Name
_____ Title	_____ Relationship
_____ Date	_____ Date

AUTHORIZATION FOR ADMINISTERING MEDICAL TREATMENT TO CHILDREN WITH SEVERE ALLERGIES

Date _____

Dear Doctor _____

Your patient, _____ is enrolled/enrolling in our School and we have been requested to provide certain medical treatment for the prevention of anaphylaxis in the event the child comes into contact with certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at our school so we may assist with the allergy care and needs of our student and your patient. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, that will become a part of this record and will be kept with this form in the child's file at _____ School.

Child's name: _____
Child's date of birth: _____

PART I (to be completed by physician)

ALLERGENS:

Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction, (i.e. anaphylactic shock) in the child.

_____ Bee sting

_____ Other insect bite(s): (Identify) _____

_____ Animal fur: (Identify) _____

_____ Food Allergy: (Identify all foods that must be avoided) _____

_____

_____ Other: (Identify) _____

_____

SYMPTOMS:

Please provide a complete list of all symptoms indicating that the child has come into contact with an allergen and that he/she requires emergency treatment.

_____ Shortness of breath or difficulty in breathing

_____ Swelling of the face or lips

_____ Hives

_____ Vomiting

_____ Diarrhea

_____ Other: (Explain) _____

_____ Do not administer medication in the absence of known exposure to allergen. (Explain) _____

PROCEDURES:

Please indicate all steps necessary and the order in which they should be taken.

_____ Give Benadryl Elixir orally (dosage _____)

_____ Administer EpiPen, Jr. or _____

_____ Call the area's emergency medical personnel (e.g. "911")

_____ Call parent(s)/guardian(s), and child's physician

_____ Other (Explain) _____

RECREATIONAL ACTIVITIES:

1. The child may participate in recreational activities. ( )Yes ( ) No

2. Activity restrictions: ( ) None ( ) Some restrictions
(Explain): _____

_____

CHILD'S PHYSICIAN:

Name: _____

Address: _____

Telephone #: _____

Emergency contact #: _____

Signature: _____ Date: _____

PART II (to be completed by parents)

Parent(s)/Guardian(s):

Name: _____

Address: _____

Telephone #: _____

Emergency Contact #: _____