AUTHORIZATION FOR SELF-ADMINISTRATION OF ANAPHYLAXIS (AUTO-INJECTIBLE EPINEPHRINE) MEDICATIONS BY STUDENTS IN THE COLUMBUS MUNICIPAL SCHOOL DISTRICT

I/We, the undersigned parent(s) or guardian(s) of ______________________________, authorize the school/school district to permit my/our child to self-administer anaphylaxis (auto-injectable epinephrine) medications. I/We understand that is my/our responsibility to provide the proper medication to my/our child, to insure that my/our child carries his/her medication with them, and that my/our child is properly instructed on the self-administration of the medication. I/We understand that a written statement must accompany this authorization from my/our child's physician or health care provider verifying that he/she has anaphylaxis and has been instructed in self-administration of anaphylaxis (auto-injectable) medications. The statement must also contain:

1. The name and purpose of the medication;
2. The prescribed dosage;
3. The times at which or circumstances under which the medications are to be administered;
4. The length of time for which the medications are prescribed;
5. The signature of the child's health care practitioner; and
6. The date the statement was signed.

RELEASE AND INDEMNITY AGREEMENT: I/We forever release, discharge and covenant to hold harmless the Columbus Municipal School District, its personnel, agents, employees, volunteers, and Board of Trustees from any/all liability claims, demands, damages, expenses, loss of services, and causes of action belonging to my/our child or to the undersigned arising out of or on account of any injury, sickness, disability, death, loss of damages of any kind resulting from self-administration of the anaphylaxis (auto-injectable epinephrine) medicines except in cases of willful or wanton conduct.

I/We agree to repay the school district, its personnel, agents, employees, volunteers, or Trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any such injury or death to my/our child as a result of self administration of the anaphylaxis (auto-injectable epinephrine) medicines except in cases of willful or wanton conduct.
I/We have red the foregoing release and indemnity agreement and fully understand it.

Executed this the _________ day of ___________________, 20_____.

****CHILD REQUIRES ASSISTANCE IN ADMINISTERING ANAPHYLAXIS MEDICATION. (Yes _____ No _____)**

______________________________	______________________________
Witness	Parent/Guardian
______________________________	______________________________
Witness	Parent/Guardian

PHYSICIAN'S AUTHORIZATION FOR SELF ADMINISTERED ANAPHYLAXIS (AUTO-INJECTABLE EPINEPHRINE) MEDICATION

Dear Dr. ________________________________

The policy of the Columbus Municipal School District and current state law regarding the matter of self-administration of anaphylaxis (auto-injectable epinephrine) medication requires a written statement from the student's physician or health care provider, indicating that the student has anaphylaxis and has received instructions in self-administration of anaphylaxis (auto-injectable epinephrine) medication. Medications that are administered at school must be properly labeled as to substance, dosage, and patient name. Written authorization from the student's parent/guardian is also required.
Sincerely,

Billie Beard, RN	Sharon Reifers, RN	Katie Elliott, RN	Marlisia Pierce, RN	Maris Braddock,RN	Shonenn Fant, RN
Stokes-Beard	Franklin & CMSD Alt	Cook Elementary	Sale & Fairview	Columbus Middle	Columbus High
Ph#-241.7270	Ph#-241.7150	Ph#-241.7180	Ph#-241.7260	Ph#-241.7300	Ph#-241.7200
Fax-241.7272	Fax-241.7152	Fax-241.7182	Fax-241.7262	Fax-241.7305	Fax-241.7208

TO BE COMPLETED BY THE PHYSICIAN

______________________________ has received instructions in the self-administration of ______________________________
Patient's Name — Medication

for anaphylaxis, and is to self-administer ____________________ of this medication at ______________________________.
Dosage — Date/Time

SIDE EFFECTS: ____

TERMINATION DATE: ______________________________ COMMENTS/CONDITIONS:______________________________

______________________________	______________________________
Name of Physician (Please Print)	Signature of Physician
______________________________	______________________________
Telephone Number/Fax Number	Street Address, City