

SACRED HEART SCHOOL  
620 Valley Brook Avenue  
Lyndhurst, New Jersey 07071  
(201) 939-4277

Administration of Epi-Pen

Student Name \_\_\_\_\_

DOB \_\_\_\_\_ Grade \_\_\_\_\_

As parent/guardian of \_\_\_\_\_, I request the administration of epinephrine via a pre-filled single dose auto-injector mechanism.

Attached are physician's orders requiring the administration of the Epi-Pen to my child who does not have the capability for self-administration.

I understand that if the procedures specified in N.J.S.A. 18A:40-12.5 are followed, the non public school shall have no liability as a result of any injury arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine to my child, and I shall indemnify and hold harmless the non public school and its employees or agents against any claims arising out of administration of a pre-filled single dose auto-injector mechanism containing epinephrine to my child.

I will provide a current Epi-Pen and will responsible for replacing it when it has expired.

This permission is valid for the \_\_\_\_\_ school year *only*.

Parent/Guardian Signature \_\_\_\_\_

Parent/Guardian Name (printed) \_\_\_\_\_

Date \_\_\_\_\_

School Principal Signature \_\_\_\_\_

School Nurse Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Consent for Delegate Administration**

STUDENT NAME \_\_\_\_\_

D.O.B. \_\_\_\_\_ GRADE \_\_\_\_\_

As parent/guardian of \_\_\_\_\_, I consent to the administration of epinephrine by \_\_\_\_\_, via a pre-filled single dose auto injector mechanism.

I acknowledge and understand that if the procedures specified in the "Protocol and Implementation Plan for the Emergency Administration of Epinephrine by a Delegate trained by the School Nurse" are followed, the non public school shall have no liability as a result of any injury arising from the administration of a pre-filled single dose auto-injector mechanism containing epinephrine to my child. I shall indemnify and hold harmless the non-public school and its employees or agents against any claims arising out of administration of a pre-filled single dose auto-injector mechanism containing epinephrine to my child.

This permission is valid for the \_\_\_\_\_ school year *only*.

Signature of Parent/Guardian \_\_\_\_\_

Parent/Guardian Name (printed) \_\_\_\_\_

Date \_\_\_\_\_

School Principal Signature \_\_\_\_\_

School Nurse Signature \_\_\_\_\_

Date \_\_\_\_\_

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AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

STUDENT NAME \_\_\_\_\_

GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

FREQUENCY GIVEN & DIRECTIONS \_\_\_\_\_

\_\_\_\_\_

PURPOSE \_\_\_\_\_

POSSIBLE SIDE EFFECTS \_\_\_\_\_

**I authorize the School Nurse or her designee to administer the above medication.**

\_\_\_\_\_  
*Physician's Signature*

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Physician's Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Address*

\_\_\_\_\_

\_\_\_\_\_  
*Phone*