**Mount Holly Township Public Schools**
Office of the Superintendent
331 Levis Drive
Mount Holly, NJ 08060
Phone: (609) 267-7108
Fax: (609) 702-9082

## Epi-Pen Delegation Permission Form

Student: _____ School Year: _____

I _____, give permission for my child to receive auto-injector
(Parent/Guardian)
epinephrine (Epi-Pen) by the school nurse or designee(s). I understand by signing this permission form, the school district shall have no liability as a result of any injury arising from the administration of the auto-injector epinephrine (Epi-Pen) by the school nurse or designee(s) to the pupil and that the district, it's employees, and agents shall be indemnified and held harmless against any claims arising out of the administration of the auto-injector epinephrine (Epi-Pen) to the pupil.

_____ _____
(Date) (Parent/Guardian Signature

## PERMISSION TO GIVE EPINEPHRINE AT SCHOOL
FORM C

Dear Parent / Guardian:

The Mount Holly Township School District requires that all students who may need medication during school hours must do the following:

1. Present a doctor's note stating the name of medication, dosage, diagnosis and length of time of medication is to be given.
2. Present a written consent form signed by the parent / guardian.
3. Bring the medication to school in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.
4. The Board shall permit the school nurse or medical inspector to administer epinephrine via epi-pen in emergency situations. If a child has a documented case of anaphylaxis by a physician or advance practice nurse and is not capable of self-administration, a designee who is employed by the Board may administer the epi-pen in the event the nurse is not present.

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### EPINEPHRINE PERMISSION FORM

Name of Student:_____

### TO BE COMPLETED BY PHYSICIAN

Allergen/s student reacts to:_____

Name of medication:_____

Dosage:_____ Route of administration:_____

Specific time(s) to be given, i.e. immediately or wait for early s/s to develop:_____

_____

Possible side effects:_____

Can students self-administer? Yes_____ No_____

Does this child have a documented case of anaphylaxis? Yes_____ No_____

Are there any restrictions? Yes_____ No_____ If yes, what and how long?_____

_____ _____ _____

Physician Name (printed) Signature of Physician Date

### TO BE COMPLETED BY PARENT / GUARDIAN

I, _____ give permission for my child to receive auto injectable epinephrine by the school nurse or designee(s). I understand by signing this permission the district shall have no liability as a result of any injury arising from the administration of the auto injectable epinephrine by the school nurse or designee(s) to the pupil and that the district, its employees, and agents shall be indemnified and held harmless against any claims arising out of the administration of the auto injectable epinephrine to the pupils.

_____ _____ _____

Date Parent / Guardian Signature Phone Number

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# MOUNT HOLLY TOWNSHIP SCHOOLS

## MEDICATION FORM

To be completed by a PHYSICIAN:

Name of student _____ Grade _____

Medication _____

Dose, time and route _____

Purpose _____

For school trips – omit that dose: _____ yes _____ no

Physician signature _____

Physician name/stamp _____

Address _____

Phone _____ Date _____

To be completed by PARENT/GUARDIAN:
I request that the above medication, in its original container, be administered to my child. I release the Mount Holly School Board and personnel from all liability. I give the School Nurse permission to contact the Physician and/or Pharmacist with any questions concerning the medication.

Signature of Parent/Guardian _____

Date _____

***MEDICATION MUST BE IN ORIGINAL CONTAINER TO BE DISPENSED IN SCHOOL***

***ALL UNUSED MEDICATION MUST BE PICKED UP AT THE END OF THE SCHOOL YEAR BY THE PARENT***

***Medication will be discarded if not picked up by the last day of school.***