

**STUDENT: ANAPHYLAXIS**

FORM- REQUEST AND CONSENT FOR

ADMINISTRATION/ INJECTION OF MEDICATION IN AN EMERGENCY

Section 1STUDENT NAME: _____
FIRST NAME LAST NAMESTUDENT NUMBER: _____ STUDENT DOB: _____ GRADE/PLACEMENT: _____
(YYYY-MM-DD)**Section 2****THE PARENT(S)/GUARDIAN REQUEST AND CONSENT FOR THE ADMINISTRATION OF AN INJECTION OF MEDICATION IN AN EMERGENCY IN THE SCHOOL**_____
PARENT GUARDIAN FIRST NAME PARENT GUARDIAN FIRST NAME_____
HOME/CELL TELEPHONE HOME/CELL TELEPHONE_____
WORK PHONE: WORK PHONE:

I/We request that _____ School provide the administration of an emergency injection of medication for my/our son/daughter in the event that the following should happen:

Section 3**I/We understand that:**

- a medical doctor must consent to this request in accordance with **Section 2** of this form;
- only a limited supply of the medication may be kept at the school as prescribed by the doctor;
- the medication must be brought to the school in a closed container and the label must detail the name of the student, the type/name of the medication, and the size of the dosage.
- if the medication is not provided to the school, contact will be made with the parent(s)/guardian or doctor, and will also be made with parent(s)/guardian or doctor under any other exceptional circumstances, e.g. student refuses medication.
- it is the responsibility of the school to establish fall back positions for the administration of emergency medication.

I/We consent to:

- the establishment of a service at the school to administer an emergency injection of medication to my/our son/daughter named above in the event of an emergency situation as outlined above;
- school personnel responsible for the administration of medication in an emergency situation discussing any aspect of the service with a public health nurse where the need arises.

DATE: YYYY-MM-DD_____
PARENT SIGNATURE_____
PARENT SIGNATURE