Auto-Injectable Epinephrine Plan

School _____

School Year _____ Date _____

Student Name: _____ Date of Birth: _____
Teacher: _____ Grade Level: _____
Parents/Guardians:
Home Phone: _____ Work Phone (Mother): _____
Cell Phone: Work Phone (Father):

Emergency Contact: _____
Name Relationship Phone

Physician: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of ("Student") to notify the school nurse/medical professional or designee of any changes in my child's health condition and/or medication/treatment regimen. As parent or legal guardian of the above named student, I understand that my signature on this document authorizes representatives of Henry County Schools to communicate about/receive information regarding my child/ward from my child's physician and his/her staff. I understand that this health information will only be shared with pertinent school staff.

By signing below, I acknowledge that I have read, understood, and agree to the terms of Henry County Schools' Auto-Injectable Policy. I authorize Henry County Schools, its employees, and agents to seek medical treatment for my child, if at their discretion, they deem such medical treatment is necessary and appropriate. By signing this Auto-Injectable Epinephrine Plan, I release Henry County Schools, its employees, and agents from all civil liability including but not limited to issues pertaining to the Student's self-administrating auto-injectable epinephrine, storage and security of auto-injectable epinephrine, and the decision of Henry County Schools' employees and agents to administer or not to administer auto-injectable epinephrine.

Parent/Guardian Signature Date

Completed by Physician (Attach additional pages if necessary)

Medical History:

Medial Diagnosis	Chronic/Acute	Severity	Prognosis

Description of Medical Condition (symptoms, behaviors, etc):

Medication Regimen:

Medication Name	Dosage(Amount)	When to Use

Treatment Regimen/Emergency Services:

Individual Considerations (Please indicate any special diet, physical activity limitations/adaptations, prosthetic devices, special procedures/interventions, and/or impact on school attendance):

Physician Printed Name Physician Signature Date