

MINATO SCHOOL
CONSENT TO ADMINISTER PRESCRIPTION AUTO-INJECTABLE EPINEPHRINE

Student's Name: _____ Date of Birth: _____

Check all allergies that apply:

- Peanut Tree Nuts Shell Fish Milk Insect Stings
 Egg Latex Medications _____
 Other: _____

My child has previously had the following symptoms from an anaphylactic reaction:

- SKIN: hives swelling itching warmth redness rash
RESPIRATORY: wheezing shortness of breath tight throat cough
GASTROINTESTINAL: nausea pain/cramps vomiting diarrhea
CARDIOVASCULAR: pale blue color weak pulse passing out dizziness

I, the parent/guardian of the student named above, request that Minato School assist my child in administering epinephrine auto-injectable medication (EpiPen®/Twinject®/Adrenaclick®) in the event it appears he/she is having an anaphylactic/allergic reaction. My child knows the signs and symptoms of an allergic reaction and is able to use epinephrine auto-injectable medication. I give my consent for Minato School staff to administer, help my child administer, or allow my child to administer, this medication.

I have been informed by my child's physician that this medication is medically appropriate for my child. The physician has explained to me and my child the nature, effect and possible side effects of this treatment and I accept all responsibility for the same. I understand that this service will be provided by Minato School staff who may not have any medical or nursing training.

My child (*check one*) has asthma does not have asthma. I understand that people with asthma have a higher risk of anaphylaxis. I and my child have discussed this with my child's physician and have been advised whether my child should receive epinephrine auto-injectable medication before taking asthma medication if he/she is having an anaphylactic reaction and has difficulty breathing. If I have checked this box: my child should receive epinephrine auto-injectable medication BEFORE taking asthma medication if he/she is having an anaphylactic reaction and has difficulty breathing.

I understand that epinephrine injection is used along with emergency medical treatment to treat life-threatening allergic reactions and that further emergency medical treatment is necessary. I hereby authorize Minato School (and its staff) to consent to, authorize, provide or arrange for ambulance or other transportation as reasonably necessary for my child to obtain emergency medical care.

I will immediately inform Minato School of any changes in the physician's instructions or the medication, and understand that it is my responsibility to keep Minato School informed at all times.

I will supply up-to date (unexpired) epinephrine auto-injectable medication as ordered by my child's physician and make sure my child always carries it with him/her at all times. The medication will be located in my child's: _____ (*specify location, such as "backpack"*).

I understand that my child will be subject to disciplinary action he/she uses the epinephrine auto-injectable medication in a manner other than as prescribed by his/her physician (e.g., playing with

it, giving it to another student, etc.). I understand that this is for the protection of my child and other students.

WAIVER OF LIABILITY: I agree to hold Minato School and its officers, directors, employees, agents, volunteers, students and insurers free and harmless from any and all responsibility, liability, suits or claims of whatever nature or kind, which may arising from or relate to this Consent, the administration of epinephrine auto-injectable medication, or lack thereof, or the manner in which it is administered.

Parent/Guardian Signature: _____ Date: _____

Name Printed: _____

This form must be accompanied by the following completed and signed forms:

- Student Medical History Form
- Student Medical and Personal Information and Authorizations
- Physician's Recommendations For Auto-Injectable Epinephrine Medication
- Authorization for Use or Disclosure of Health Information (Related to Administering Epinephrine Auto-Injectable Medication)

The information in this form must be updated every year by the parents/guardians and the parents/guardians must promptly report any changes in the information to Minato School.

MINATO SCHOOL

**PHYSICIAN'S RECOMMENDATIONS FOR AUTO-INJECTABLE EPINEPHRINE
MEDICATION**

Student's Name _____ Date of Birth: _____

TO BE COMPLETED BY A LICENSED PHYSICIAN

1. The nature of the condition requiring epinephrine auto-injectable medication during the school day is: _____

2. The name of the epinephrine auto-injectable medication, method of administration and dosage is:

3. The epinephrine auto-injectable medication should be administered when: _____

4. The epinephrine auto-injectable medication must be furnished by the parent.

5. Other instructions: _____

Physician's Signature: _____ Date: _____

Name Printed: _____ License No: _____

Address: _____

Telephone _____

MINATO SCHOOL

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(Related to Administering Epinephrine Auto-Injectable Medication)

EXPLANATION: This form authorizes the use or disclosure of protected health information for the student named below in the manner described. Signing this Authorization is required in order for Minato School to agree to assist your child in administering epinephrine auto-injectable medication in the event it appears that the child is having an anaphylactic/allergic reaction.

Child's Name: _____ Date of Birth: _____

USE AND DISCLOSURE AUTHORIZATION: I, the parent/guardian of the child named above, authorize (name and address of health care provider) _____

to provide health information from the child's medical record to and from Minato School, 9150 Chesapeake Drive, Suite 170, San Diego, CA 92123.

Disclosure of the health information is required for the purpose of my request that Minato School assist my child in administering epinephrine auto-injectable medication in the event it appears that the child is having an anaphylactic/allergic reaction. The requested health information should be limited to the minimum information necessary for that purpose.

DURATION: This authorization shall become effective immediately and shall remain in effect until (*enter date*) _____, or for one year from the date of my signature, if no date has been entered.

RESTRICTIONS: California law prohibits Minato School, as the requestor of the health information, from making further disclosure of my child's health information unless the Minato School obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I hereby release the named health care provider from any/all legal liability that may arise from the release of this information to Minato School.

PARENT/GUARDIAN'S RIGHTS: I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care provider named above. My revocation will be effective upon receipt, but will not be effective to the extent that Minato School or others have acted in reliance on this Authorization.

RE-DISCLOSURE: I understand that Minato School will protect this information as prescribed by law and that the information becomes part of the child's school record. The information will be shared with individuals working with Minato School for the purpose of health-related services to be provided to my child.

COPY OF AUTHORIZATION: I have a right to receive a copy of this Authorization.

Parent/Guardian Signature: _____ Date: _____

Name Printed: _____