Permit for Self-Administration of Emergency Epinephrine for Legacy Kids Care

Student_____School_____DOB_____Grade____

Legal Reference: ARS 15-341 (2005) allows students who have been diagnosed with anaphylaxis by a healthcare provider to carry and self-administer emergency medications including auto-injectable epinephrine while at school and at school sponsored activities. The student's name on the prescription label on the medication container or on the medication device is sufficient proof that the pupil is entitled to the possession and self-administration of the medication. The statute also provides immunity from civil liability for a school district and its employees with respect to all decisions made and actions taken that are based on good faith implementation of the requirements of this paragraph, except in cases of wanton or willful neglect.

Name of medication_____

Dosage_____ Expiration Date_____

I hereby give permission for my child to carry the above listed medication as ordered by his/her licensed healthcare provider. I understand that my child, not the school, is responsible for the storage, possession, and use of the self-administered medication. I understand that misusing medication or sharing medication with other students will result in disciplinary action. I agree to deliver the medication to the school health office with an appropriate pharmacy prescription label and to provide the health office with a back-up medication. I understand that it is the responsibility of my child to report to the Health Office or other staff member if symptoms do not improve after taking this medication.

"Self-Administration" means that my child has the discretion to use his/her medication appropriately. Therefore as parent/guardian, I acknowledge that my child is capable of identifying the medication, is knowledgeable of the purpose of the medication, is able to identify/associate specific occurrence and need for the administration of the medication, is knowledgeable/capable of medication dosage, is knowledgeable/capable of administrative method, is able to state side effects/adverse reactions to the medication, and is knowledgeable of how to access assistance for self if needed in an emergency.

I acknowledge that Athlos Traditional Academy/Legacy Traditional Schools and its employees will be immune from civil liability for all decisions made and actions taken in good faith to implement these provisions per ARS 15-341 and ARS 15-344. I also acknowledge that Athlos Traditional Academy/Legacy Traditional Schools and its employees will be exempt from civil liability as a result of any injury arising from my child's self-administration and/or misuse of the medication.

Parent/Guardian Name_____

Parent/Guardian Signature_____Date_____

Prescribing Physician Name_____Ph. Number_____

I have read the above and understand my responsibility to carry and self-administer my medication and will notify the Health Office or other staff member if my symptoms do not improve after taking this medication.

Student Signature_____Date_____

☐ (Office Use) Check if Emergency Action Plan is complete and on file