2023-2024 Epinephrine Authorization Form

Merritt ACADEMY
Enjoy the Journey

This form authorizes Merritt Academy to administer epinephrine to your child.

- **Two (2) doses of Epinephrine MUST be provided.**
- **The Epinephrine must be in the original container, label with the appropriate prescription and student name.**
- **A physician's authorization is required.**

PART 1 PARENT OR GUARDIAN TO COMPLETE

I hereby request Merritt Academy (MA), personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless Merritt Academy and any of their officers, staff members, or agents from lawsuits, claims, expenses, demands, or actions, etc., against them for helping this student use medication, provided Merritt Academy staff members comply with the physician, parent or guardian orders set forth in accordance with the provision of part I and II below.

Child's Name:	Date of Birth:	Classroom/Grade:

Diagnosis/Allergy/:

Medication Name:

EPINEPHRINE

☐ 0.3ml _____ ☐ 0.15ml_____

If medication is given on an as-needed basis, specify the symptoms or conditions when medication is to be taken and the time at which it may be given again.

Any Adverse Reactions:

Special Instructions (if any):

Merritt Academy has my permission to administer the medication above. I authorize any adult at Merritt Academy to administer epinephrine to the above-named student as outlined above.
(Note: Authorization by a physician is additionally required)

_____ (Parent's Signature)

_____ (Printed Name)

This medication is effective from: _____ (first day administered) and until _____ or ☐ August 14th, 2024

Authorization may not exceed the last day of the 2023-24 program

PART II PHYSICIAN AUTHORIZATION (IF ADMINISTERED MORE THAN 10 DAYS)

I certify that, in my opinion, it is medically necessary that the medication and dosage described above be administered to the child listed above during the hours of operation at Merritt Academy.

_____ Physician's Signature

_____ Printed Name

_____ Date

FOR MERRITT ACADEMY OFFICE USE ONLY

Date Received:_____ Office Approval:_____ Medication Expiration Date: _____

Refill Date: _____ Office Approval:_____ Medication Expiration Date: _____