Glen Rock Community School
600 Harristown Road
Glen Rock, NJ 07452
201-389-5011

Authorization for EpiPen to be administered

Child's Name _____ _____ ____ ___ _____
Last First sex grade date of birth

If necessary, I request that my child be administered an EpiPen by the appropriate personnel. I also authorize the release of pertinent medical information to be exchanged with the appropriate professional staff involved in the care of my child.

Parent/Guardian Signature _____ Date _____

The following is to be completed by the PHYSICIAN.

Diagnosis _____

Dose: _____

If EpiPen is to be given "WHEN NEEDED", describe indications _____

_____

How soon can it be repeated? _____

List significant side effects: _____

Please initial here if you give your child permission to self-administer. _____

Please have your doctor initial here if he/she feels you child may self-administer._____

Physician's signature: _____

Print Name: _____

Address: _____

Phone number: _____ Date:_____

Parents shall indemnify and hold harmless the Glen Rock Board of Education from any and all injuries sustained by their child, except as to such injuries that result directly from acts of negligence on the part of the Glen Rock Board of Education.