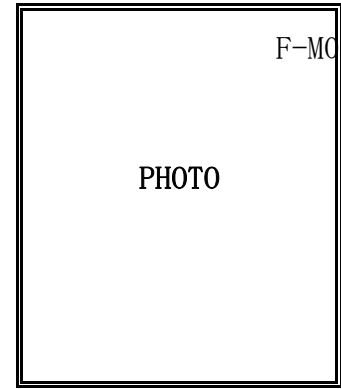




Sudbury Student Services
Consortium
de services aux élèves de Sudbury



REQUEST FOR THE ADMINISTRATION OF AN EPIPEN

Please type or print information

A. STUDENT IDENTIFICATION

Name _____

Date of Birth (m/d/yr) _____

Parent or Guardian _____

Telephone - Home _____ Bus. a) _____ b) _____ Emergency # _____

Address (home) _____

Address (sitter) _____ Sitter Telephone Number _____

School _____ Grade _____ Teacher _____

Health Insurance Card Number _____

Allergy _____

1. Administration frequency per school day / as required _____ other _____

2. Cautions / Notable Side-effects / Storage Duration _____

Location of the EpiPen on person or in school bag _____

B. PARENT or GUARDIAN INFORMED AUTHORIZATION AND RELEASE

I/we hereby request that the administration of an EpiPen be provided. It is further agreed that the student will carry the medication. It is the responsibility of the parent or guardian for identifying the child to the driver(s) and advising the driver(s) of the EpiPen's location. I/we agree to provide the Sudbury Student Services Consortium with an updated medical statement whenever there is a change in the physician's instructions with respect to medication.

I/We hereby release the Sudbury Student Services Consortium, the school Boards, its employees and agents from all manner of actions, causes of action, claims, suits, losses, damage or injuries ("actions or proceedings") arising out of the administration of the EpiPen Auto Injector ("EpiPen") and/or medication as requested and consented by me/us. We do also hereby indemnify and save harmless the Sudbury Student Services Consortium, the school Boards, its employees and agents for any losses or damages sustained by them as a result of any such actions or proceedings being taken against them by any person including without limiting the generality of this, myself/ourselves, our child, any other parent or guardian of our child.

I confirm that Dr. _____ has fully explained to me and to my child (name) _____ the nature, effect and possible side effects of such treatment and hereby acknowledge that I have read and fully understand the terms set out herein. I have received a copy of the Sudbury Student Services Consortium's policy and procedures in this regard, and I have read and understood their contents and agree to abide by the terms set out.

I confirm that there is a signed physician statement in my child's file at their school of attendance.

Medical Condition _____

Allergy to _____

Date _____ Parent or Guardian _____ Parent or Guardian _____

Physician Name _____ Address _____ Telephone Number _____

REQUEST FOR THE ADMINISTRATION OF AN EPIPEN

FOR OFFICE USE ONLY

SCHOOL BUS OPERATOR

A.M. Route Number _____

Driver _____

Mid-day Route Number _____

Driver _____

P.M. Route Number _____

Driver _____

Allergy _____

Medical Information _____

C. AUTHORIZATION ON BEHALF OF TRANSPORTATION

Executive Director, Sudbury Student Services Consortium

Date

DISPATCH

1. Obtain exact location and time of administration.
2. Call 911 and advise that you have a student going into shock due to an allergic reaction.
3. Maintain radio contact.
4. Call the Executive Director of the Sudbury Student Services Consortium.
5. The Consortium's Executive Director will contact the parent or guardian and school.