COVENANT
CHRISTIAN ACADEMY

Office of the School Nurse

Parent/Guardian Consent for Administration of Epinephrine & Anti-Histamine

Student's Name:_____Grade:_____DOB:_____
Address: _____
Allergy: _____
MD:/phone: _____
Parent/Guardian:_____
Home phone: _____
Cell phone(s): _____
Work phone(s): _____

Emergency Contact: (if parent can not be reached)

Name: _____ Phone:_____ _____

I/We give permission to allow the administration of epinephrine via auto-injection (Epi Pen), according to the physician medication order/Allergy Action Plan, by the school nurse or by an unlicensed member of the school staff who has been trained in epinephrine auto-injection by the school nurse, to my child in the event of an anaphylactic emergency. I give consent for the school nurse to share this information with appropriate school personnel. I understand that 911 will be called per school policy in the event of an Epi-Pen administration.

_____ _____
parent/guardian signature date signed

I/We give permission to allow the school nurse to administer an anti-histamine (i.e. Benadryl) according to the physician medication order/Allergy Action Plan.

_____ _____
parent/guardian signature date signed

_____ _____
RN signature/document reviewed date signed

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