

# Calumet Christian School

Effective March 22, 2007, Ohio Senate Bill 164 permits students to carry and use an epinephrine auto-injector with the written approval of their parents and health care provider

## PERMISSION TO CARRY AND SELF-ADMINISTER EPINEPHRINE AUTO-INJECTOR (EpiPen)

### Parent to Complete

**Purpose:** To permit students to possess and use prescribed medications during school hours when regular attendance at school would be impossible without the medication.

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Student Name

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Address

Telephone

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Date of Birth

School

Room #

**To the Parent or Guardian:**

**THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES OR USES PRESCRIBED MEDICATION IN SCHOOL; BOTH THE PARENT AND PHYSICIAN PORTIONS OF THIS FORM MUST BE COMPLETED.**

1. I am requesting permission for the student named above to possess and use medication according to the doctor's verification on this card.
2. I will assume responsibility for the safe delivery of the medication to school, either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the medication.
4. I authorize Calumet Christian School personnel to communicate with my child's health care provider as necessary concerning the use of this medication.
5. I understand the Xenos Christian Schools, members of the School Board or school employees are not liable in damages in a civil action for injury, death, or loss to person or property arising from prohibiting a student to use an auto-injector because of the employee's good faith belief that the conditions set forth in ORC 3313.718 have not been satisfied, or for allowing the student to use the auto-injector if the conditions have been satisfied or from the use of the auto-injector by an unauthorized user.

**As the Parent/Guardian of the above named student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at the school and any activity, event or program sponsored by, or in which the student's school is a participant. I will instruct my child to inform school personnel if he/she has used the auto-injector so that the school employee can immediately call 911. I will provide a backup dose of the medication to the principal or school nurse as required by law.**

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Signature of Parent or Guardian

Date

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Home Telephone

Work Telephone

Cell Phone

Emergency Contact Number(s):

\_\_\_\_\_  
(Telephone #)

\_\_\_\_\_  
(Name and relationship to student)

\_\_\_\_\_  
(Telephone #)

\_\_\_\_\_  
(Name and relationship to student)

Reverse side to be completed by Healthcare Provider

