

**Ohio Department of Health**  
**Authorization for Student Possession and Use of an Epinephrine Autoinjector**  
 In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

**This section must be completed and signed by the student's parent or guardian.**

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

<b>Parent/Guardian signature</b>	Date
Parent/Guardian name	Parent/Guardian emergency telephone number (      )

**This section must be completed and signed by the medication prescriber.**

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief	
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**Possible severe adverse reactions**

To the student for whom it is prescribed (that should be reported to the prescriber)
To a student for whom it is <b>not</b> prescribed who receives a dose
Special instructions
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As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

<b>Prescriber signature</b>	Date
Prescriber name	Prescriber emergency telephone number (      )

Developed in collaboration with the Ohio Association of School Nurses

# Your Road Map to Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 1

Ohio students must provide a completed form to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector at school or at any activity, event or program sponsored by or which the student's school is a participant.

The Epinephrine Autoinjector or Severe Allergy Medication Administration Record consists of two parts and may also include other forms including an Allergy Action Plan, Emergency Action Plan, Individualized Healthcare Plan, Individualized Education Plan, 504, etc. The following guide is number/color coded for parents, school staff and prescribers.

Please do your part to ensure that children get the medication they need.

## Guidelines for Completing Road Map

<p><b>Parent/Guardian:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Part 1: Complete <b>Section A</b></li> <li><input type="checkbox"/> Part 2: Complete Sections <b>A</b> and <b>B</b>. Complete <b>Section C</b> if applicable</li> <li><input type="checkbox"/> Attach a recent photo of your child to form</li> </ul>	<p><b>School Staff:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review parent/guardian and prescriber sections for completeness in <b>Columns 1-6</b> and <b>Section A</b></li> <li><input type="checkbox"/> Keep extra blank forms available</li> </ul>
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<p><b>Prescriber:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fill in the Prescriber's Order columns 1-6 (ensure that student's name and address is complete in <b>Section A</b>)             <ul style="list-style-type: none"> <li><b>Column 1:</b> Include medication name(s), dates and list allergens. Complete an Allergy Action Plan to accompany the MAR form so families/school can follow treatment plans and use medications correctly</li> <li><b>Column 2:</b> Provide specific indications (dosage, time) for administration of medications including PRN</li> <li><b>Column 3:</b> List possible severe adverse reactions</li> <li><b>Column 4:</b> Write any special instructions. Indicate if additional backup epinephrine autoinjector has been prescribed to be kept at school (per law)</li> </ul> </li> <li><input type="checkbox"/> <b>Section 5:</b> List other home medications</li> <li><input type="checkbox"/> <b>Section 6:</b> Fill in prescriber's name and emergency contact information</li> </ul>
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Epinephrine Autoinjector or Severe Allergy Medication Administration Record			
<p style="font-size: 2em; font-weight: bold; margin: 0;">A</p> <p style="margin: 0;">Student Name, Sex, Date of Birth, Home Address, Student ID, Grade/Class, Teacher, School</p>	<p style="font-size: 0.8em;">Student Photo</p>		
<p style="font-size: 0.8em;">Medication Name and Start/End Date</p> <p style="font-size: 0.8em;">1. Medication</p> <p style="font-size: 2em; font-weight: bold; text-align: center; margin-top: 20px;">1</p>	<p style="font-size: 0.8em;">Dosage, Route and Time Interval</p> <p style="font-size: 0.8em;">Standard Order</p> <p style="font-size: 2em; font-weight: bold; text-align: center; margin-top: 20px;">2</p>	<p style="font-size: 0.8em;">Possible Severe Adverse Reactions</p> <p style="font-size: 2em; font-weight: bold; text-align: center; margin-top: 20px;">3</p>	<p style="font-size: 0.8em;">Special Instructions</p> <p style="font-size: 2em; font-weight: bold; text-align: center; margin-top: 20px;">4</p>
<p style="font-size: 0.8em;">2. Medication</p>	<p style="font-size: 0.8em;">Standing Daily Dose</p>	<p style="font-size: 0.8em;">Possible Severe Adverse Reactions</p>	<p style="font-size: 0.8em;">Special Instructions</p>
<p style="font-size: 0.8em;">3. Medication</p>	<p style="font-size: 0.8em;">Standing Daily Dose</p>	<p style="font-size: 0.8em;">Possible Severe Adverse Reactions</p>	<p style="font-size: 0.8em;">Special Instructions</p>
<p style="font-size: 0.8em;">List Home medications</p> <p style="font-size: 2em; font-weight: bold; text-align: center; margin-top: 20px;">5</p>	<p style="font-size: 0.8em;">Prescriber Address</p> <p style="font-size: 2em; font-weight: bold; text-align: center; margin-top: 20px;">6</p>	<p style="font-size: 0.8em;">Prescriber Signature:</p> <p style="font-size: 2em; font-weight: bold; text-align: center; margin-top: 20px;">6</p>	<p style="font-size: 0.8em;">For Nurse Use</p>

## Your Road Map to Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 2

Part 2 of the Epinephrine Autoinjector or Severe Allergy Medication Administration Record must be completed by parents/guardians and school staff.

Please do your part to ensure that children get the medication they need.

### Epinephrine Autoinjector Medication Administration Record (MAR)

#### Student Information

**A**

##### Parent/Guardian

- Complete student information in Section A

#### Parent Authorization

**B**

##### Parent/Guardian

- Complete Section B to authorize administration of medication(s) at school, in accordance with prescriber orders

#### Self-Carry Authorization

**C**

##### Parent/Guardian

- Complete Section C to authorize your child to self carry and self administer epinephrine autoinjector as prescribed

#### School Staff Only

**D**

- Section D for use by SCHOOL STAFF only.

# Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 1

(Parent/guardian signature required on Part 2). A completed form must be provided before the student may possess and use an epinephrine autoinjector to alleviate anaphylaxis in schools.

Student Photo  
(Must attach)

Student name	Student address	Student ID#	Height/Weight (optional)
Grade/Class	School		

## Medication order in this section must be signed by the licensed prescriber

Medication Name and Start/End Date	Dosage Route and Time Interval (Specify signs, symptoms or situations)	Possible Severe Adverse Reactions	Special Instructions (Choose all that are appropriate)
<p><b>1. Medication</b></p> <p><input type="checkbox"/> <b>See Allergy Action Plan</b> Extremely reactive to the following foods (allergen): _____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> EpiPen® Autoinjector</p> <p><input type="checkbox"/> EpiPen® Jr Autoinjector</p> <p><input type="checkbox"/> Other epinephrine autoinjector _____</p> <p>Diagnosis: _____</p> <p>Begin Date: _____</p> <p>End Date (if known): _____</p>	<p><b>Time</b></p> <p><b>2</b></p> <ul style="list-style-type: none"> <li>• If checked below, give ordered epinephrine immediately for ANY symptoms if the allergen was likely eaten.</li> <li>• If checked below, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted</li> <li>• Other _____</li> </ul> <p><b>Standard Order (Intramuscular or subcutaneously into the anterolateral aspect of the thigh) PRN for</b></p> <p><input type="checkbox"/> EpiPen® 0.3 mg/0.3 mL (2 mL) 1:1000 sterile solution, delivers 0.3 mg per injection <input type="checkbox"/> May repeat in 15-20 minutes</p> <p><input type="checkbox"/> EpiPen® Jr 0.15 mg/0.3 mL (2 mL) 1:2000 sterile solution, delivers 0.15 mg per injection <input type="checkbox"/> May repeat in 15-20 minutes</p> <p>Note: EpiPen® &amp; EpiPen® Jr each contain 2mL epinephrine solutions. Approximately 1.7 mL remain in the autoinjector after use and cannot be reused.</p> <p><input type="checkbox"/> <b>Other epinephrine autoinjector medication</b> _____ <input type="checkbox"/> Twin pak</p> <p>Dose _____ <input type="checkbox"/> May repeat in 15-20 minutes</p> <p>2. <b>Call 911</b> (per law if autoinjector used)</p> <p>3. Begin monitoring</p>	<p><b>3</b></p> <p><b>Possible Severe Adverse Reactions per ORC 3313.718:</b></p> <p><input type="checkbox"/> To the student for whom it is prescribed (that should be reported to the physician)</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> To the student for whom it is <b>NOT</b> prescribed who receives a dose</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p>	<p><b>4</b></p> <p><b>Special Instructions</b></p> <p><input type="checkbox"/> As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector. <b>(Parent must also sign Part 2)</b></p> <p><input type="checkbox"/> Backup dose is ordered. (parent will provide a backup dose of the medication to the school principal or nurse as required by law)</p> <p><input type="checkbox"/> <b>Procedures to follow if the medication does not produce the expected relief</b> _____</p> <p>_____</p> <p><input type="checkbox"/> <b>Procedures to follow if student is unable to administer anaphylaxis medication</b> _____</p> <p>_____</p> <p><input type="checkbox"/> Store medication in school health room and student to self-administer under observation</p> <p><input type="checkbox"/> Store medication in school health room and nurse or school staff to administer in emergency</p> <p><b>Other</b> _____</p> <p>_____</p>
<p><b>2. Medication</b></p> <p>Diagnosis: _____</p> <p>Begin Date: _____</p> <p>End Date (if known): _____</p>	<p><input type="checkbox"/> Standing Daily Dose</p> <p><b>Specify Time</b> _____ am <b>and/or</b> <input type="checkbox"/> pm</p> <p><b>Time Interval</b> every (q) _____ hours as needed</p> <p>_____</p> <p>(specify signs, symptoms or situations)</p> <p><input type="checkbox"/> Standing Daily Dose</p> <p><b>Specify Time</b> _____ am <b>and/or</b> <input type="checkbox"/> pm</p> <p><b>Time Interval</b> every (q) _____ hours as needed</p> <p>_____</p> <p>(specify signs, symptoms or situations)</p>	<p><b>Possible Severe Adverse Reactions Reportable to Prescriber</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Special Instructions</b></p> <p><input type="checkbox"/> Store medication in school health room and nurse to administer</p> <p><input type="checkbox"/> Requires refrigeration</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p>
<p><b>3. Medication</b></p> <p>Diagnosis _____</p> <p>Begin Date _____</p> <p>End Date (if known) _____</p> <p>List Home medication(s) _____</p> <p>_____</p> <p style="text-align: right; font-size: 2em;"><b>5</b></p>	<p><input type="checkbox"/> Standing Daily Dose</p> <p><b>Specify Time</b> _____ am <b>and/or</b> <input type="checkbox"/> pm</p> <p><b>Time Interval</b> every (q) _____ hours as needed</p> <p>_____</p> <p>(specify signs, symptoms or situations)</p>	<p><b>Possible Severe Adverse Reactions Reportable to Prescriber</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Special Instructions</b></p> <p><input type="checkbox"/> Store medication in school health room and nurse to administer</p> <p><input type="checkbox"/> Requires refrigeration</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p>
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="text-align: right; font-size: 2em;"><b>6</b></p>	<p><b>Prescriber</b> (please print) _____</p> <p><b>Prescriber address</b> _____</p> <p>_____</p> <p>_____</p>	<p><b>Prescriber signature/date</b> _____</p> <p><b>Prescriber Emergency phone</b> _____</p> <p><b>Fax</b> _____</p>	<p><b>For Nurse Use Only: (Revision per Licensed Nurse after consultation with prescribing provider)</b></p> <p>_____</p> <p>_____</p> <p>_____</p>

## Epinephrine Autoinjector or Severe Allergy Medication Administration Record (MAR) Part 2

Prescriber order(s) and signature required on Part 1. A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector in school to alleviate allergy symptoms

### Student Information

# A

Student name	Date of birth
Student address	Grade/Classroom

### Parent/Guardian Authorization

# B

<input checked="" type="checkbox"/> I authorize a designated employee of the school board to administer the prescribed medication as ordered for my child <input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist should a question come up about the medication <input checked="" type="checkbox"/> Medication and medication form must be received by the principal, his/her designee or the school nurse <input checked="" type="checkbox"/> I understand that the medication must be in the <b>original container</b> and be <b>properly labeled</b> with the student name, prescriber name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate <input checked="" type="checkbox"/> By law, I agree that it is important to keep a back up epinephrine autoinjector at the school's designated location <input checked="" type="checkbox"/> I understand I must to come into the school office/clinic when my child's medication is discontinued by the prescriber or at the end of the school year, or medication will be disposed of one week post-discontinuation orders or school year end			
Parent/Guardian signature	Date	#1 contact phone (     )	#2 contact phone (     )

### Self-Carry Authorization

# C

<b>Parent must <input checked="" type="checkbox"/> below to indicate student is allowed to self-carry their epinephrine autoinjector</b> <input type="checkbox"/> I authorize and recommend self-medication by my child for the prescribed listed medication <input type="checkbox"/> I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending prescriber			
Parent/Guardian signature	Date	#1 contact phone (     )	#2 contact phone (     )

### Do not write below (For school staff only)

# D

Reviewed by	Title/Position	Date
Comments		