

**TMCSEA  
SCHRAMM EDUCATIONAL CENTER**

**SCHOOL EPINEPHRINE  
ADMINISTRATION/AUTHORIZATION OF HEALTHCARE SERVICES AND/OR TREATMENTS**

**Student's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Home District:** \_\_\_\_\_

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize TMCSEA and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of TMCSEA), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction, whether such reactions are known to me or not (105 ILCS 5/22-30, amend by P.A. 99-480). I am aware that immediate activation of EMS is required after any administration of Epinephrine auto-injector (105 ILCS 5/22-30(f-5), amended by P.A. 99-480). **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices**, and I agree to indemnify and hold harmless TMCSEA and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication. I authorize the school to fax this completed authorization to my child's healthcare provider for his/her signature and I authorize that provider to fax this information back to the school.

**Yes, I agree to allow auto injector epinephrine to be administered to my child (per body weight recommendations).**

**Child's Current Weight:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**No, I do NOT want auto injector epinephrine to be administered to my child.**  
If you checked no, YOU are responsible for having your child's physician complete the items below.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Date Signed

\_\_\_\_\_  
Physician's Emergency Phone #

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Parent Date Signed