2020-2021 EPINEPHRINE AUTO-INJECTOR MEDICATION PLAN

LEXINGTON CHRISTIAN ACADEMY
450 West Reynolds Road, Lexington KY 40503

Lexington Christian Academy has adopted a procedure wherein a member of the staff of the campus the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by Andrew Carlson, LCA's Head Athletic Trainer and BLS Certified Instructor, and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's physician in the case of a life-threatening emergency wherein immediate intervention is required by the staff member. The undersigned Parent/Guardian does hereby consent to the intervention of the staff member in accordance with the Physician's instructions. Additionally, the undersigned agrees to hold that staff member harmless for any injuries resulting from the emergency care unless the injury was caused by the staff member's negligence.

Student's Name: _____ **DOB:** ___ / ___ / ___

Campus: _____ **Grade Level:** _____ **Homeroom Teacher:** _____

Parent/Guardian Name: _____ **Cell #:** _____

Parent/Guardian Name: _____ **Cell #:** _____

Emergency Contact (if unable to reach Parent/Guardian) _____

Cell #: _____ **Relationship:** _____

PHYSICIAN'S ORDER FOR EMERGENCY ACTION PLAN

To be completed by the student's Physician and returned to the applicable campus office.

Allergen: _____

Student's Typical Reaction: _____

Student's Other Known Allergies: _____

Action to Be Taken:

1. **If ingestion/exposure is suspected, give:**
   _____ **Medication/Dose/Route**

   _____ **Medication/Dose/Route**
2. ***Call Rescue Squad (911) if Epinephrine Auto-Injector is used.***
3. **Notify Parent/Guardian or Emergency Contact.**

I believe this student is able to carry and administer his or her own medication at the appropriate time and in the appropriate way. This student has been instructed on the indication for medication usage and methods of administration. Please check: Yes ▪ No ▪

Physician's Name: _____ **Phone #:** _____

Physician's Signature: _____ **Date:** _____

PARENT/GUARDIAN STATEMENT

▪ I, the undersigned Parent/Guardian of _____ request that a trained staff member administer the above medication to the student per Physician instructions. I agree to furnish the necessary prescribed medication and agree to notify the School Administrator immediately of any changes. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed.

▪ I, the undersigned Parent/Guardian of _____ give consent for my student to self-administer the above medication(s). I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. The School Administrator reserves the right to monitor the student periodically throughout the year. Parent/Student are responsible to have medication available at school. Self-Administered medication not provided or monitored by school staff.

Parent's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

School Administrator's Signature: _____ **Date:** _____