AUTO-INJECTOR CONSENT FORM

Name of Pupil	
Date of Birth	**Form**
Medication and strength	
Expiry date of medication	
Any precautions or side effects	

Please tick each appropriate box to indicate agreement/consent:
You must tick either box 2 or 3, or both

1 I can confirm that my child has been diagnosed with an allergic reaction which may cause anaphylaxis and has been prescribed an auto-injector. ☐

2 I wish the school to hold ____* autoinjector(s) for my child to administer in accordance with their care plan and the school's Managing Illness & Medicine policy. I understand that I must deliver the autoinjector to the main office/reception for the first aiders ☐

3 I hereby give my consent for my child to carry ____* working, in-date injector(s), clearly labelled with their name, which they will bring with them to school every day. I confirm that my child will also carry their auto-injector(s) on any trips/visits taken off the school premises ☐

4 I understand I am responsible for ensuring that all autoinjectors are replaced prior to their expiry date(s) ☐

5 In the event of my child displaying symptoms of an anaphylactic reaction, if their own auto-injector is not available, has expired or is unusable, or should an additional dose be required, I consent for my child to receive adrenaline from an auto-injector held by the school for such emergencies ☐

6 I understand that the auto-injectors held by the school are 300mcg Jext or EpiPen ☐

7 I attach a copy of my child's Allergy Action Plan / Care Plan and I will inform the school immediately, in writing, if there is any change to my child's diagnosis or treatment ☐

Signed
Name Parent/Carer (please delete as appropriate)
Contact details in an emergency
Date

*Enter number of autoinjectors to be held/carried