BEN SAMUELS
CHILDREN'S CENTER
MONTCLAIR STATE UNIVERSITY

EMERGENCY ADMINISTRATION OF EPINEPHRINE VIA AUTO-INJECTOR

RE: _____ _____
Child's Name Date of Birth

_____
Allergic Condition

A. PARENT'S/GUARDIAN'S STATEMENT

1. I/we have completed the Allergy Alert Form and disclosed that my/our child suffers from one or more allergies. In the event that my child (named above), experiences symptoms that indicate an allergic reaction, the undersigned authorizes the administration of the appropriate medication in the dosage required by the child's treating physicians indicated on the Action Plan (e.g. epinephrine via auto injector or antihistamine e.g. Benadryl) by the school nurse or such other employee(s) designated by Ben Samuels Children's Center who is properly trained in the administration of the medication. We acknowledge our understanding that the school nurse is only available on a limited, part-time basis.

2. Subject to our compliance with applicable laws, we release and hold harmless Montclair State University, the State of New Jersey, as well as its employees and agents, from liability as a result of any injury arising from the administration of medication to our child.

3. Permission for the administration of medication to our child is granted until and unless revoked in writing.

B. PARENT OR GUARDIAN MUST SIGN

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Physician must complete back portion

Mailing:
1 NORMAL AVENUE
MONTCLAIR, NJ 07043

Location:
80 CLOVE ROAD
LITTLE FALLS, NJ 07424

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