CHILD WITH SERIOUS ALLERGY

Our child, _________________________________, requires the administration of antihistamines and possibly inhalers and/or epinephrine in case of an anaphylactic or other serious allergic reaction. Our child has possible anaphylactic allergies to ____.

We understand that there are no guarantees that the GOYA-sponsored events and activities will be free from these allergens. We are aware that we may send foods deemed safe for our child's consumption during GOYA-sponsored events and activities without any expectation of reimbursement from GOYA. We also agree that the chaperones, agents, advisors and clergy are not responsible for the food we may send in with our child.

We also understand that there will not be any medical personnel assigned during GOYA-sponsored events or activities in the event of an allergic reaction. We realize that it is our responsibility to assure that our child is properly trained to self-administer their emergency medications. We also understand that it is our responsibility to assure that our child has his or her emergency medications in their possession at all times during GOYA sponsored events and activities.

We understand that we are to be aware of expiration dates and replace medications when needed. We also realize that it is the GOYAN's responsibility to identify any and all allergens and to avoid exposure to the same. By not filling out the 'need for parental supervision' form, we understand that my child will be responsible for their own allergies or medical condition. We release the St. Demetrios, Union, NJ, its priest, GOYA advisors and agents, from any liability as a result of these allergies or medical condition.

Parent/Guardian signature_____________________________ Date________________

Parent/Guardian signature_____________________________ Date________________

SELF-MEDICATION PERMISSION FORM

FOR A GOYAN WITH A LIFE-THREATENING ILLNESS/ALLERGIC REACTION

In accordance with P.L. 2007, c.57, this form must be signed by the parents/guardians of any student who wishes to self-administer and is capable of and has been instructed in the proper method of medication for a life-threatening illness or is subject to a life-threatening illness allergic reaction.

We ____(print names of parents/guardians), are the parents/guardians of ______________________________(print name of GOYAN) who is a registered member of GOYA. This form provides St. Demetrios Greek Orthodox Church in Union, NJ our written authorization for our child to self-administer medication for a life-threatening illness or is subject to a life threatening illness allergic reaction. By signing this form, we release St. Demetrios Greek Orthodox Church, Union, NJ, its priest, GOYA advisors and agents, from any liability as a result of any injury from the self-administration of medication by our child or any other consequence of an allergic reaction and we expressly agree to defend, protect, indemnify, and hold harmless St. Demetrios Greek Orthodox Church, Union, NJ, and its priest, GOYA advisors or agents, from all losses, costs, suits or claims which may result from the self-administration of medication by our child or any other consequence of an allergic reaction.

Attached to this form is the written certification of our physician verifying the diagnosis of my child as potentially life-threatening and the provision of self - medication instructions.

Permission for our child to self-administer medication is effective upon approval and notification by the undersigned. Permission remains effective only for the present GOYA/ecclesiastical year.

Parent/Guardian Signature: ________________________________ Date______

Parent/Guardian Signature: ________________________________ Date______

Physician Signature: ____Date_______

NEED FOR PARENTAL SUPERVISION

We understand that if the severity of our child, ________________________(Name of GOYAN), allergy warrants the need to have parental supervision during GOYA-sponsored events or activities, a physician's note must be submitted stating such, along with the specific life-threatening allergens listed by the physician.

We are also aware that parents who accompany allergic children will need to pay for their own expenses and are limited to the supervision of their own child.

We understand that we take full responsibility for our child and by signing this form, we release the St. Demetrios Greek Orthodox Church, Union, NJ, its priest, GOYA advisors and agents, from any liability as a result of any injury from the administration of medication to our child by myself or any other consequence of an allergic reaction and we expressly agree to defend, protect, indemnify, and hold harmless St. Demetrios Greek Orthodox Church, Union, NJ, and its priest, GOYA advisors or agents, from all losses, costs, suits or claims which may result from the administration of medication to our child by myself or any other consequence of an allergic reaction.

Parent/Guardian signature: ______________________________Date___________

Parent/Guardian signature: ______________________________ Date__________

PHYSICIAN CERTIFICATION FOR SELF-MEDICATION
BY A GOYAN WITH A LIFE-THREATENING ILLNESS/ALLERGIC REACTION

In accordance with P.L. 2007, c.57, I ___________________________________ (print name of physician) certify that I am the physician of (print name of GOYAN) _____________________________________. This patient suffers from (print name of illness) ____ a potentially life-threatening illness/allergic reaction, and is capable of, and has been instructed in, the proper method of self-administration of medication for this illness/allergic reaction.

_______________________________ (print name of GOYAN) is physically fit to attend GOYA functions.

Name of Medication: ____

Dose and Route: ____

Time: ____

Side Effects: ____

Period of time to be self -administered: ______________________________

Signature of Physician/Stamp: _____________________________________

Telephone of physician: _________________________Date_____________

Reviewed and approved by,
Signature of Priest:____