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| Collaborative Practice Agreement |
| SchoolDistrict |  |
| Address |  |
| This is a written and signed agreement between a physician licensed in the State of Maine or a school health advisor under 20-A MRSA §6402-A and a school nurse under 20-A MRSA §6403-A who represents the school district as listed above. This is meant to accompany the standing orders that are provided annually by the school health advisor. |
| Licensed Provider Name |  |
| Provider Address |  |
| Provider Phone |  |
| **Services to be provided:** |
|  ⧠ Epinephrine— This agreement permits a physician licensed in this State or school health advisor to prescribe an epinephrine autoinjector and direct a school nurse to administer an epinephrine autoinjector in good faith to any student experiencing anaphylaxis during school or a school-sponsored activity. Pursuant to this agreement, the school nurse is authorized during school or a school-sponsored activity to designate other school personnel with training required by rule to administer an epinephrine autoinjector if the school nurse is not present when a student experiences anaphylaxis.  |
|  ⧠ Epinephrine Protocol is established |
| ⧠ Naloxone— This agreement permits a physician licensed in this State or school health advisor to prescribe naloxone hydrochloride and direct a school nurse to administer naloxone hydrochloride in good faith to any student, staff member or visitor experiencing an apparent opioid overdose during school or a school-sponsored activity or otherwise on school grounds. Pursuant to this agreement, the school nurse is authorized during school or a school-sponsored activity or otherwise on school grounds to designate designated school personnel to administer naloxone hydrochloride if the school nurse is not present when a student, staff member or visitor experiences a suspected opioid overdose.   |
|  ⧠ Naloxone Protocol is established |
| Other Directions/Comments: |
| Superintendent of Schools Name: |  |
| Superintendent of Schools Signature: |  |
| Licensed Medical Provider Name: |  |
| Licensed Medical Provider Signature: |  |
| School Nurse Name: |  |
| School Nurse Signature: |  |
| Dates Effective:(to be renewed annually) |  |