PERMISSION FOR SELF-ADMINISTRATION OF EPI-PEN

ON ANY OCCASION THAT STUDENTS MUST CARRY AN EPI-PEN AT SCHOOL, THIS FORM MUST BE COMLETED AND SIGNED IN ADVANCE BY THE STUDENT'S PARENT OR GUARDIAN, STUDENT, **AND THE PHYSICIAN**. THE FORM MUST BE ON FILE IN THE SCHOOL OFFICE AND THE EPI-PEN MUST BE FURNISHED BY THE PARENT/GUARDIAN.
****

REQUEST TO SELF-ADMINISTER AND/OR CARRY EPI-PEN AT SCHOOL

STUDENT'S NAME____

MEDICATION____

REASON FOR MEDICATION____

DOSE______________________TIME(S) TO BE GIVEN____________________

DATES TO BE GIVEN____

I HEREBY REQUEST THAT_________________BE ALLOWED TO CARRY AND SELF-ADMINISTER HIS/HER EPI-PEN AS PRESCRIBED BY OUR MEDICAL DOCTOR.
PLEASE REQUEST THAT THE PHARAMCIST PLACE AN APPROPRIATE LABEL ON THE EPI-PEN SO THAT IT IS EASILY IDENTIFIED.

I REALIZE THE PRIVILEGE OF SELF-ADMINISTRATION MAY BE REVOKED AT ANY TIME IF MY STUDENT IS NOT HANDLING THE MEDICATION SAFELY. I ACKNOWLEDGE THAT THE SCHOOL INCURS NO LIABILITY FOR ANY INJURY RESULTING FROM THE SELF-ADMINISTRATION OF MEDICATION TO INDEMNIFY AND HOLD THE SCHOOL, AND ITS EMPLOYEES AND AGENTS, HARMLESS AGAINST ANY CLAIMS RELATING TO THE SELF-ADMINISTRATION OF SUCH MEDICATION.

____________________________________ ___/___/___
signature of parent/guardian date

STUDENTS RESPONSIBILITY:

1. AT ALL TIMES I WILL KEEP THE EPI-PEN IN MY POSSESSION.
2. I WILL USE THE EPI-PEN ONLY AS PRESCRIBED BY MY DOCTOR.
3. I WILL NOT SHARE THIS EPI-PEN WITH OTHERS.

I REALIZE I CAN LOSE THIS PRIVILEGE IF I MISHANDLE MY EPI-PEN.

____________________________________ ___/___/___
student's signature date

____________________________________ ___/___/___
Physician's signature date