Self-Administration of EPI-Pen Authorization Form

Circle which school attending: Capron Manchester Poplar Grove Upper Elementary Middle School High School

Student's Name: _____ Grade: _____ Birthdate: _____

Address: _____ Phone: _____

I acknowledge that my child has a severe allergic response and has been prescribed an EPI-Pen by a qualified health care professional. I hereby authorize my child to self-administer his/her EPI-Pen during school hours, at school-sponsored activities, under the supervision of school personnel, or before or after normal school activities. I have provided the School District with a written statement from the physician, physician's assistant, or advanced practice registered nurse who prescribed the EPI-Pen for my child.

I acknowledge that the School District will not be held liable for any injury to my child that results from his/her self-administration for the EPI-Pen unless the School District, its employees, and its agents are found to have engaged in willful and wanton conduct.

I agree to indemnify and hold harmless the School District, its employees, and its agents against any claims, except a claim based on willful and wanton conduct, arising out of my child's self-administration of the EIP-Pen.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

Name of Medication:	Dosage:
Allergy requiring this medication:	
Common side effects:	
Time interval for reevaluation:	Discontinuation date:
Other medications student is receiving:	

I hereby acknowledge that the above student has a life-threatening allergy. He/she will need the administration of epinephrine after he/she has been in contact with the cause of the allergy to prevent a life-threatening situation. The student understands the need for the medication and is capable of using this medication independently.

Date:
*Physician's signature
*Physician's name (print):
Address:
Phone:

*Physician's assistants must have been delegated the authority to prescribe the EPI-Pen by their supervising physician. Advanced practice registered nurses must have written collaborative agreement with a collaborating physician delegating the authority to prescribe an EPI-Pen.