

## Authorization For Student To Self Administer Epi-pen

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade / Room: \_\_\_\_\_

**TO BE COMPLETED BY PARENT / GUARDIAN We / I understand and agree that:**

1. The Epi-pen will be furnished by me.
2. The Epi-pen must be labeled with the name of the student and medication.
3. My child is to carry his / her Epi-pen at all times while at school and on the bus.
4. My child has been trained adequately on the correct use of the Epi-pen.
5. My child will notify the nurse each time the Epi-pen is used.

**Signature of Parent / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TO BE COMPLETED BY STUDENT: I understand and agree that:**

1. I will be responsible for carrying my Epi-pen if authorized by my parent and physician to do so.
2. I will NEVER loan my Epi-pen to anyone else or invite anyone to try it.
3. If I do so I may face disciplinary action.
4. I will demonstrate to the nurse proper technique in using my Epi-pen.
5. I will notify the nearest adult when I use my Epi-pen and will ask for immediate emergency assistance.

**Signature of Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TO BE COMPLETED BY SCHOOL NURSE:**

This student has demonstrated proper inhaler use in my presence. At the secondary level, demonstration will be done at the nurse's discretion after review of health record.

**Signature of School Nurse:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN: Student is able to self-administer Epi-Pen**  YES  NO

Name of Medication: \_\_\_\_\_

Route and dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Duration: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Reason for Administration: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

We / I hereby release, discharge and hold harmless the East Penn School District, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to our / my child. We / I have read and agree to the above policy.

**Signature of Parent / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**District Fax Numbers:**

School Name	Fax Number	School Name	Fax Number
Alburtis	610-966-9619	Macungie	610-966-7583
EHS	610-966-8449	Shoemaker	610-965-2977
Eyer Middle	610-966-9649	Wescosville	610-395-6354
Jefferson	610-966-8349	Willow Lane	484.519.3310
Lincoln	610-965-1569	Student Services	610-965-1628
LMMS	610-398-4385		