

Permission for Student to Carry and Self-Administer Prescribed Epinephrine

Student Name: _____ **Grade/Teacher:** _____

Medication(s) to self-carry: _____

According to Missouri Law, students may be allowed to carry and self-administer prescribed medication while at school, at a school-sponsored activity and in transit to or from school or school-sponsored activity when they meet the following requirements:

- A physician prescribed the medication for use by the student and instructed the student in the correct and responsible usage of the medication.
- The student has demonstrated to the student's licensed physician or the licensed physician's designee, and the school nurse the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered.
- The student's physician has approved and signed a written treatment plan for managing the student's chronic health condition, including asthma or anaphylaxis episodes and for medication for use by the student. Such plan shall include a statement that the student is capable of self-administering the medication under the treatment plan. The plan may be effective only for the same school year it is granted and must be renewed each year.
- The student's parent/guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan and a liability statement acknowledging the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by the student.

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER EMERGENCY MEDICATION FOR SEVERE ALLERGIES:

I certify that the above named student has a medical history of potentially life-threatening allergies, has been instructed in the proper self-administration of the medications(s) listed above and is judged to be capable of carrying and self-administering the medication(s). The student has been instructed to notify or have someone notify the school nurse if any signs or symptoms of an allergic reaction occur. This student understands the hazards of sharing medications with others and has agreed to refrain from the practice. I have provided a Food Allergy Action Plan for the student to follow and provide a copy to the school.

Physician Signature: _____ Date: _____

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER MEDICATION:

I, the parent/guardian of the above named student, give permission for this student to carry and self-administer the above listed medication(s). I have reinforced that my student should notify the school nurse if any sign or symptoms of an allergic reaction occur. I acknowledge that the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of the medication by my student.

Parent/Guardian Signature: _____ Date: _____

Responsibilities for Self-Care of Severe Allergies: (to be checked by the School Nurse)

Yes No Student is able to identify signs and symptoms of an allergic response & need for epinephrine administration

Yes No Student agrees to come directly to Health Room following an allergic response

Yes No Student demonstrates proper self-administration technique to ensure good delivery of epinephrine

Yes No Student has another epinephrine auto-injector in Health Room for back up (recommended, not required)

Yes No Student knows that medication carried must have prescription label attached, to identify medication's owner

School Nurse Signature: _____ Date: _____