LEE'S SUMMIT R-7 SCHOOL DISTRICT

SELF-ADMINISTRATION PROCEDURE FOR USE OF EPI-PEN/Auvi-Q

THIS MEDICATION AUTHORIZATION IS ONLY VALID FOR THE CURRENT SCHOOL YEAR

Student Name: _____**DOB:**_____**School Year:** _____ Grade: _____

Parent/Guardian: _____**Phone:**_____

Physician: _____**Phone:**_____

Medications

- ❑ Epi-pen 0.3mg/Auvi-Q 0.3mg
- ❑ Other_____
- ❑ Physician has provided Personal Food Allergy Action Plan **OR** ❑ Student will follow LSR7 Treatment of an Allergic Reaction Plan

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER: I certify that the above named student is at risk for having anaphylaxis, has been instructed in the proper self-administration of the medication(s) listed above and is judged to be capable of carrying and self-administering the listed medication(s). In the event of a life-threatening allergic reaction, the student will sit down, administer the Epi-pen/Auvi-Q and immediately notify a school staff member of the situation. This student understands the hazards of sharing medications with others and has agreed to refrain from this practice.

Physician Signature: _____**Date**:_____

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER: 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 instructed my student that in the event of a life-threatening allergic reaction, the student will sit down, administer the Epi-pen/Auvi-Q and immediately notify a school staff member of the situation. I acknowledge that the school district and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by my student or the administration of such medication by school staff.

Parent/Guardian Signature: _____**Date:** _____

SCHOOL PLAN: School will follow Personal Food Allergy Action Plan if parents have provided one to the school. If no Personal Food Allergy Action Plan has been provided, then the LSR7 Treatment of an Allergic Reaction Plan will be followed.
Student has Personal Food Allergy Action Plan in file: ❑ yes ❑ no

RESPONSIBILITIES FOR CARRYING EPI-PEN/Auvi-Q: (to be checked by the School Nurse)

YES	NO	
□	□	Student is able to identify signs and symptoms of a life-threatening allergic reaction.
□	□	Student demonstrates correct technique of self-administration of Epi-pen/Auvi-Q with Epi-pen/Auvi-Q trainer.

School Nurse Signature: _____

MEDICATION MUST BE DISPENSED FOLLOWING THE LSR7 SCHOOL DISTRICT MEDICATION POLICY. THE STUDENT CARRYINGING THEIR EPI-PEN WILL BE RESPONSIBLE FOR THE SELF-ADMINISTRATION OF THEIR MEDICATION AS DIRECTED BY THEIR PHYSICIAN. THE PRIVILEGE OF CARRYING AN EPI-PEN FOR SELF-ADMINISTRATION MAY BE WITHDRAWN IF THE STUDENT DOES NOT COMPLY WITH THE SCHOOL DISTRICT'S POLICY AND PROCEDURES (Reference Board Policy JHCD).