Written Authorization for Self-Administration of EpiPen®, EpiPenJr. ® or other epinephrine auto-injectors by Minor Children at School

Student Name: _____ Date of Birth: _____ Grade: ____

I, _____, Parent/Legal Guardian of the above-named student, hereby request authorization for self-administration and possession of EpiPen® and EpiPenJr.® or other epinephrine auto-injectors by this student while in school, at a school-sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school-operated property. The student demonstrates full understanding of the proper use of his/her allergy medication.

I understand that: • Glascock County Consolidated School, its employees, and agents, shall incur no liability for: • any injury to the student caused by his or her self-administration of medication except for injury caused by willful or wanton misconduct; • the student's use, misuse, overuse, or neglected or failed use of his/her allergy medication; • lost, misplaced, outdated, inaccessible, empty, or faulty allergy medication and allergy devices. • the school may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with allergy medication; • the school has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of allergy medication, and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for: • the monitoring of allergy medication, medication use, and refilling of prescriptions for allergy medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered allergy medication; • ensuring the student always carries his/her allergy medication on his/her person; • deciding if back-up medication will be kept at the school and providing the school with the back-up medication; • informing school staff in writing of any changes in the student's treatment or allergy management; • informing the school of any allergy exacerbations, hospital visits, and/or new or changed student medical information; • informing school staff in writing of any medication side effects that warrant communication to the parent/guardian; • coordinating distribution of the student's allergy management and emergency plan to school staff.

I understand and agree to the conditions of the school system policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above-named student. I release Glascock County Consolidated School, its employees, and agents, of any legal responsibility related to the above-named student's possession and self-administration of his/ her allergy medication.

_____

Parent/Legal Guardian Signature Date

I, _____,the above-named student, have been instructed in the proper use of my prescription allergy medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

_____

Student's Signature Date