



**PERMISSION FORM FOR STUDENT TO  
INDEPENDENTLY USE PRESCRIBED EPI-PEN**

Date: \_\_\_\_\_

Your son/daughter \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
has indicated that a prescribed epi-pen is being used to treat severe allergic reactions..

Please sign below to indicate it is your belief that your son/daughter, as indicated, is capable of self-medication on an as needed basis. He/she will also be held responsible for having the appropriate medication at school, sporting events, and school trips.

Your physician's signature is also required.

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

M.D. Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE RETURN TO THE NURSE'S OFFICE**



**FORUMLARIO / PERMISO  
PARA EL USO DE 'EPI-PEN'**

Fecha: \_\_\_\_\_

Su hijo(a) \_\_\_\_\_ Grado: \_\_\_\_\_ FDN: \_\_\_\_\_  
ha indicado que usa "Epi-pen" como medicina para prevenir reacciones alérgicas.

Por favor, firme este documento si considera que su hijo(a) puede tomar dicha medicina por sí mismo y hacerlo correctamente. Asimismo, su hijo(a) es responsable por llevar consigo, durante el día escolar, deportes y viajes, su medicación.

Se requiere también la firma de su médico.

Firma del padre \_\_\_\_\_ Fecha: \_\_\_\_\_

Firma del médico \_\_\_\_\_ Fecha: \_\_\_\_\_

**POR FAVOR RETORNAR ESTE DOCUMENTO  
A LA ENFERMERA DEL COLEGIO**