EPINEPHRINE CONSENT FORM

(STUDENTS WITH IDENTIFIED SYSTEMIC ALLERGIES)

I authorize trained school personnel to administer my child's epinephrine auto-injector according to the physician's instructions below. I understand that the Epi-pen must be in the original container with the pharmacy's prescription label. If my child is given physician consent to self-carry at school, then I assume responsibility for ensuring that the medication is current and that my child understands the appropriate handling of this medication.

_____ _____

Parent/Guardian Signature Date

Please Note: To ensure ready access to medications at school, it is recommended that students have 2 sets of medications: One in the classroom/self-carry, and one at the health office.

PHYSICIAN ORDER

I give permission for the following medication to be administered as directed to the student named below for the 2024-2025 school year.

Student Name: _____ **D.O.B:** _____

Allergy to: _____

If exposed to named allergy above, administer _____, _____tsp by mouth and call the child's parents.
(Medication/concentration)

If he/she develops any of the following symptoms, please administer Epinephrine: ___Epi-pen Jr ___Epi-pen (adult) and call 911.

List of Symptoms:

_____

_____

PERMISSION TO SELF-CARRY:

____ Yes, I have instructed this student in the proper way to use his/her medication. It is my opinion that he or she should be allowed to carry and self-administer this medication at school or at any school sponsored field trips.

____ No, it is my opinion that this student should not carry and self-administer this medication at school or any school sponsored field trips.

_____ _____

Physician Signature Date