PERMISSION FOR STUDENT TO SELF-ADMINISTER MEDICATION BY EPINEPHRINE AUTO INJECTOR FOR SCHOOL YEAR _____

Student's Full Name_____ Date of Birth _____ Grade_____

Parent/Guardian Name & Phone Number(s) _____

Emergency Contact & Phone Number(s) _____

To be Completed by Parent/ Guardian

I hereby certify the following:

- I _____, am the parent or legal guardian of_____ ("Student"), a student in the Parkway School District ("District"), and am legally authorized to make educational and health care decisions for the Student.
- I hereby give my permission for the Student to retain in his/her possession an epinephrine auto injector (EpiPen/AuviQ/generic), and to self-administer medication from such injector. This permission shall be effective during the school day; on school property, including but not limited to a school bus; and at all school activities, whether on or off school property or occurring during the regular school day.
- I have provided the District with a written medical history of the Student's experience with severe allergy or other potentially life-threatening anaphylaxis ("Condition") and a plan of action for addressing any emergency situations that could reasonably be anticipated as a consequence of administering the medication and having the Condition.
- I have provided the District with written certification from the Student's physician, stating that the Student (a) has the aforementioned Condition and (b) is capable of, and has been instructed in, the proper method of self-administration of medication and informed of the dangers of permitting other persons to use the medicine prescribed for the Student.
- I understand that the District and its employees or agents may disclose information provided in accordance with the foregoing paragraphs to administrators, school nurses, teachers, and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-administer medication by means of an auto injector, and shall incur no liability for the disclosure of such information.
- I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the Student, and that I shall be required to indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by the Student.
- I understand that this permission form is effective for the school year for which it is granted, and that a new permission form and supporting documentation as described above, must be submitted for each school year.
- I agree to supervise that my child carries his/her auto injector, that the expiration date on the device is current, and that the device is labeled with the student's name and prescription label.
- It has been recommended to me that a back-up auto injector be provided to the Health Office for emergencies.
- I have been advised to provide a complete Food Allergy Action Plan from our physician.
- My student will ☐ regularly carry his/her auto injector ☐ carry auto injector on field trips ☐ carry to transport auto injector to/from school.

Signature of Parent/Guardian _____ Date _____

To be Completed by Physician/Licensed Prescriber

Physician/Licensed Prescriber's Name _____ Phone_____ Fax _____

Allergy _____ Epinephrine auto injector (EpiPen/AuviQ/generic) Dose_____

Medication is administered ☐ with any exposure ☐ with any symptoms ☐ with severe symptoms ☐_____

If needed, how soon can epinephrine be repeated? _____ Food Allergy Action Plan Attached ☐ Yes ☐ No

_____(student) has been instructed in the proper way to use his/her auto injector and not to share medication with others. It is my professional opinion that he/she should be allowed to carry and use this medication as prescribed if needed. **ALWAYS CALL 911 IF EPINEPHRINE AUTO INJECTOR IS ADMINISTERED.**

Physician's Signature_____ Date_____

Approved by School Nurse ☐ Yes ☐ No Signature _____ Date_____