# OWEN J. ROBERTS SCHOOL DISTRICT

SECTION: PUPILS

TITLE: POSSESSION/USE OF EPINEPHRINE AUTO-INJECTORS

ADOPTED: 1/14/13

REVISED: 10/12/15

**EPINEPHRINE AUTO-INJECTORS – SELF-ADMINISTRATION BY STUDENTS**

_____ _____ _____

Student's Name Grade Date

To self-medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate the proper technique for self-administering his/her medication.

_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.

_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

_____ _____ _____

Name of Medication Dosage Frequency

This student is capable of self-administering the prescribed epinephrine auto-injector.

_____ _____

Date Signature (Prescribing Physician)

The above named student has demonstrated the ability to self-administer the physician-prescribed epinephrine auto-injector, as indicated by the criteria listed above.

_____ _____

Date Signature (Certified School Nurse)

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it

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is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/ sharing of the above named medication will result in the immediate confiscation of the injector and loss of privilege to self-administer if the medication policy is violated.

_____ _____

Date Parent/Guardian Signature

I agree to be solely responsible for my epinephrine auto-injector and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my epinephrine auto-injector.

_____ _____

Date Student's Signature