Queen Bee School District 16
1560 Bloomingdale Road
Glendale Heights, IL 60139

EPI-PEN
ADMINISTRATION FORM
To be completed by physician

STUDENT NAME: _____

NAME OF MEDICATION _____

DOSAGE _____

DURATION OF ADMINISTRATION _____

DIAGNOSES _____

INTENDED EFFECT: _____

POSSIBLE SIDE EFFECTS: _____

Is this student allowed to carry and self-administer the Epi-pen during the school day and at school-sponsored functions?

☐ **Yes**
☐ **No**

_____ _____
Physician Name **Physician Signature**

_____ _____
Phone **Date**

Additional physician orders: _____

_____

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EPI-PEN
ADMINISTRATION FORM
To be completed by the parent

STUDENT NAME: _____ BIRTHDATE: _____
SCHOOL_____GRADE:_____
PARENT NAME:_____
EMERGENCY TELEPHONE _____
DIAGNOSES_____ _____
NAME OF MEDICATION:_____
DOSAGE:_____

I,_____(parent/guardian) of_____(student's name), hereby authorize Queen Bee Schools, District 16 and its employees and agents, in my behalf and stead, to administer to my child or allow my child to self-administer (if applicable), while under the supervision of the employees and agents of the School District, lawfully prescribed Epi-pen in the manner described above. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the School District, its employees, and agents arising out of the administration of said medication. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

My child is allowed to self-carry, AND self-administer prescribed ANAPHYLACTIC MEDICATION (EPI-PEN) during the school day and during school functions.

☐ **YES** (student is responsible for maintaining possession of an Epi-Pen during school day and all school functions)

☐ **NO** (Epi-Pen will be maintained in the health office)

Parent/GuardianSignature_____Date_____