EPIPEN ADMINISTRATION FORM

The following student has been identified as needing an EpiPen when at school or school related activities. **All medication(s) must be in the container labeled by the pharmacy.** According to policy, the school will call 911 when a student uses his/her EpiPen.

Student's Name _____ Birthdate _____

Grade _____ Teacher _____

Name of Physician/Health Care Provider _____

TO BE COMPLETED BY STUDENT'S PHYSICIAN/HEALTH CARE PROVIDER:

Name of Medication: _____

Dosage: _____

Reason for having EpiPen _____

Check one choice:

_____ Student WILL NOT carry the above noted medication but will report to the school office immediately for assistance.

_____ Student WILL carry and self-administer the above noted medication in a responsible manner. The student has demonstrated proper technique in administering this medication. Student will then immediately report to the school office after self-administration

Check one choice:

_____ Give Epi_en immediately if child states he/she is exposed to allergen.

_____ Give EpiPen if child states exposure to allergen AND exhibits difficulty breathing, wheezing, swelling of face, throat, or tongue, hives over body, or loss of consciousness, nausea/vomiting, dizziness, or other signs and symptoms.

Other symptoms: _____

_____ _____

Physician/Health Care Provider Signature Date of Signature

Office Address _____

_____ Phone Number _____

TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN: I give my child's school permission to facilitate the administering of the above medication. I further hereby agree to hold the school harmless from any liability related to the administration of said medication. My child's school reserves the right to rescind this permission if it is the good faith belief of the principal that this medication is being administered or stored inappropriately.

_____ _____

Parent/Guardian Signature Date of Signature

TO BE COMPLETED BY THE STUDENT: I will use this medication only as prescribed:

_____ _____

Student Signature Date of Signature

_____ _____

Homeroom Teacher Signature Date of Signature

_____ _____

Principal Signature Date of Signature

MEDICATION ADMINISTRATION RECORD

Name _____ Birthdate _____ Grade _____

Medication/Dosage	Date	Date	Date	Date	Date	Date	Date	Date	Date

Initials/Signature _____

_____

_____