BIG WALNUT

LOCAL SCHOOL DISTRICT

SELF MEDICATION FOR EPINEPHRINE AUTO-INJECTOR AUTHORIZATION FORM

Student Name: ____

Student Address: ____

Street Address (Subdivision) (Apt.# / Lot#) City, State, Zip

Reason for carrying EpiPen® (circle one): Bee Sting Peanuts Tree Nuts Other

If circling other, please specify: ____

Medication Name: ____

Dosage: ____

Adverse reactions that should be reported to the physician: __________________________

____

Other instructions: ____

____

NOTE: When completing this form a Food Allergy Action Plan, filled out by the parent and physician should also accompany the Epinephrine Auto-injector Authorization Form to assist us with any additional procedures or instructions to ensure the safe care of the student with an allergy while at school.

By signing below the physician or other health care provider and parent/guardian state that it is their request that the child carry the epinephrine auto-injector on their person at the school and at school functions; they realize that because the student is self-administering medication, no adult may be aware that the student is experiencing difficulty, preventing adults from responding appropriately in an emergency; and that the child has been fully trained in the use of the epinephrine auto-injector, knows why, how and when to use it properly and will not give the epinephrine auto-injector to any other students.

I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

In the event that the epinephrine auto-injector is abused or misused by the student or others, school personnel have the responsibility to assume control of the epinephrine auto-injector and contact the parent/guardian to assess the next best action for the student, classmates and others.

Physician Name: ___________________________ Phone #:___________________________

Signature: _________________________________ Date: _______________________________

Parent /Guardian Name: ____________________ Phone #:___________________________

Signature: _________________________________ Date: _______________________________

By signing below the student states an understanding of the circumstances of his/her specific allergy, symptoms of severe reaction or anaphylaxis and identify the need for epinephrine and mastery of technique of administration of Pippen® with another person. The student agrees to NEVER share the Pippen® with another person. The student agrees to seek adult help IMMEDIATELY in the event of exposure to a known allergen (regardless whether or not epinephrine was administered).

Student Signature: _________________________ Date: _______________________________

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