

Date _____

EpiPen Self-Administration Form

Student Name

Birth Date

Address / City / State / Zip

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____

Health Care Provider Authorization

The above named student is under my care. I feel it is medically appropriate for the student to self-administer an EpiPen medication and be in possession of an injectable anaphylactic medication at all times. The medication prescribed for this student is:

Name of Medication _____

Dosage _____

Possible Side Effects _____

Signature of Health Care Provider

Date

Parent/Guardian Authorization

I **DO** authorize my child _____ to carry and self-administer the medications described above.

Parent/Guardian Signature

Date

I **DO NOT** authorize my child to carry and self-administer this medication. Please keep my child's medication with appropriate school personnel.

My child and I understand there are serious consequences for sharing any medications with others.

Parent/Guardian Signature

Date