Authorization for Student to Carry Epipen

School Year: ______________________________ Date: ______________

Student's Name: ______________________________ Grade/Teacher: ______________

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Health Care Provider: (Physician, Physician Assistant, Nurse Practitioner)

Name: ____

Address: ____

Phone: ______________________ Fax: ______________________

Medication:

Name: ____

Route: ______________________ Dosage: ______________________

Other medical conditions requiring medication: ______________________

Any special side effects, contraindications, adverse reactions to be observed:

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Any severe reaction that may occur if a pupil other than the above-named received an Epipen Injection:

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Healthcare Provider's Statement

I request that the above-named student be allowed to carry at school. I have verified the student's knowledge and skill to safely possess and use the medication, as required by law.

Provider's Signature: ______________________________ Date: ______________

Parent's Statement

I request that my child carry his/her medication at school. I will provide the school with an extra Epipen to keep in the health office.

Parent's Signature: ______________________________ Date: ______________

Emergency parent contact phone number: ______________________

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School Nurse's Signature: ______________________________ Date: ______________