Authorization for Student to Carry Epipen

School Year: ______________________________ Date: ______________

Student's Name: ______________________________ Grade/Teacher: ______________

• •

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:

____

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

____

• •

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: ______________________________

• •

School Nurse's Signature: ______________________________ Date: ______________