MEDICATION PERMIT FOR EPI-PEN

Authorization for Student Possession and Use of an Epinephrine Autoinjector

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name:____ Birthdate:________________

Student address:____

School:____________________________________ Grade:________ Homeroom __________________

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law and give permission for designated school personnel to administer epinephrine in the event that my child is incapable. **I agree to hold Lakota Local School District and it's employees free from all responsibility for the administration of medication.**

Parent /Guardian signature	Date
Parent /Guardian name	Parent /Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)
Circumstances for use of the epinephrine autoinjector	
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief:	

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the physician)
To a student for which it is **not** prescribed who receives a dose
Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses. HEA 4222 3/07