2016-2017

MONDOVI SCHOOL DISTRICT

AUTHORIZATION FOR SELF-ADMINISTRATION OF EPI-PEN

(To be renewed annually and/or with any changes)

Student's Name _____ Birthdate_____Grade_____

FOR COMPLETION BY PHYSICIAN: ****State Law Requires Physician signature****

Physician's Name: _____Phone Number_____

Diagnosis: _____

Name of Medication: _____Dose_____

Is the child knowledgeable about his/her Epi-Pen medication? Yes_____ No_____

Does the child have knowledge of when the Epi-Pen should be administered? Yes_____ No_____

Has the child demonstrated the proper technique of administering an Epi-Pen? Yes_____ No_____

Medicine is administered when needed. Indications: _____

Side effects: _____

Comments: _____

( ) I have instructed_____ in the proper way to use his/her Epi-Pen. It is my professional opinion that he/she should be allowed to carry and use this medication by him/herself to help prevent the onset or alleviate the symptoms of an emergency situation.

Physicians Signature_____Date_____

FOR COMPLETION BY PARENT: ****State Law Requires Parent/Guardian signature****

Mother's Name:_____Cell or Work Phone:_____
Father's Name:_____Cell or Work Phone:_____
Home Telephone: _____
Emergency Contact:_____ Phone:_____

Is the child authorized to carry and self-administer his/her Epi-Pen? Yes____No____

I ask that my child be permitted to self medicate as authorized by my child's physician. Authorization is hereby granted for the release of this information to the appropriate health care providers and/or school staff as needed for school, health, and/or safety reasons.

PARENT/GUARDIAN SIGNATURE _____Date_____