

2017-2018  
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 \_\_\_\_\_