

2018-2019
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 _____