**NORTHMONT SCHOOL DISTRICT**

**AUTHORIZATION TO CARRY/SELF ADMINISTER EPINEPHRINE (EPI-PEN)**

Student's Name _____ DOB_____ Grade/Teacher_____

School_____ Diagnosis:_____

**SELF-ADMINISTRATION OF EPINEPHRINE MEDICATION (EPI-PEN)**

*(To be filled out by physician)*

Medication:_____

Prescribed Dosage:_____ Known Allergen:_____

Time or Circumstances to Administer Medication:_____

Start date:_____
End date:_____

***Physician Please Check <u>one:</u>***

- ▢ I have instructed _____ (student's name) in the proper way to use his/her medications. It is my professional opinion that _____ (student's name) should be allowed to carry and self-administer his/her _____(name of Epinephrine) EPI-PEN while on school property or at school-related events. **A back up dose of the EPI-PEN is REQUIRED to be located in the clinic.**

- ▢ It is my professional opinion that _____ (student's name) should **<u>NOT</u>** be allowed to carry and self-administer any of his/her Epinephrine medications while on school property or at school related events. It should be kept in a designated area (i.e. school clinic) and be accessible to the student.

Physician/Practitioner: _____ _____ _____
Printed Name Signature Date

Office Address: _____Phone: _____

<u>To Be Completed by Parent/Guardian:</u>

I permit my child access to the above listed Epinephrine as ordered by his/her physician/practitioner. **I understand that if my student is able to self-carry this medication, a backup dose of the EPI-PEN is required to be located in the clinic.** I understand that sharing medication with other students will result in disciplinary action. If the student does not follow the above agreement, the privilege of carrying and self administering his/her medication will be revoked.

Parent/Guardian Signature: _____Date: _____
Phone: _____ Cell:_____
Emergency Contact Person:_____ Relationship:_____
Phone:_____ Cell:_____
****This form is valid for one (1) school year****