

AUTHORIZATION FOR SELF ADMINISTRATION OF EPI-PEN MEDICATION

PHYSICIAN'S ORDER:

Date _____

Name of Student _____ Grade _____ Date of Birth _____

Student's Address _____ Home Phone: _____

Condition for which drug is being administered _____

Name of Drug _____ Dose & Frequency _____

Length of time during which medication shall be administered:
School Year _____/_____ or From _____ To _____
Date Date

Relevant side effects & management of _____

SELF ADMINISTRATION:

1. I have conferred with this child's parents and feel that this medication may be self-administered.
2. This student has been appropriately instructed regarding self-administration.

Physician's Signature Address Phone

PERMISSION OF PARENT OR GUARDIAN FOR SELF ADMINISTRATION OF MEDICATION

To: _____ Date _____

I hereby request that the above medication ordered by

Name of Physician
for _____ be self-administered by my child.
Name of Student

I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician.

I understand it would benefit my child for the school nurse to be supplied with back-up medication in the event the medication is lost or misplaced.

I give consent for communication between the nurse and the prescriber to ensure safe administration of the medication.

Signature of Parent/Guardian Telephone

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