



PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

Consent for Student to Carry and/or Self-Administer Emergency Medication
(EpiPen or Inhaler only)

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Name of Student

Date of Birth

Grade/Homeroom

I have prescribed **EpiPen** **Inhaler** for the student named above and the student should carry the equipment on his/her person for emergency situations. I certify the student has been taught and demonstrates the appropriate technique to self-administer.

Diagnosis/Condition being treated: _____

Specific Instructions: _____

Prescribing Physician's Printed Name

Physician's Signature

Date of Order _____ Expiration _____ Physician's Phone _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give consent for my child to carry and self-administer the medicine indicated by the doctor above during school hours or extra-curricular activities.

If administration is necessary, I understand the school nurse must be notified.

I also understand if any of the above information changes, I will contact the school nurse immediately.

Parent's Printed Name

Parent's Signature

Date _____ Parent's Phone _____