# EPI-PEN MEDICATION ADMINISTRATION FORM (SELF-ADMINISTERED)

Student's Name: _____ DOB: _____

Student's Teacher_____ School: _____Grade:_____

Parent/Guardian Name: _____ Emergency Tel#_____

Diagnosis/Condition: _____

Please list any other medical conditions requiring medication, if not a violation of confidentiality or if not contrary to the request of parents/guardian to keep confidential: _____

Name of Medication: _____

DOSE to be given at school and ROUTE: _____

FREQUENCY and TIME (s) to be given at School: _____

Should a second dose be given? Y N If so, when _____

Specific recommendations for administration: _____

Contraindications, Adverse Reactions and/or Side-effects of this medication:

_____

Severe adverse reactions that may occur to another pupil for whom the epinephrine is not prescribed, should such a pupil receive a dose of the medication: _____

Dates to be given at school OR if all year put school year date: _____

PLEASE LIST ALL MEDICATION THE CHILD IS TAKING AT HOME (Prescription and over the counter medications) if not a violation of confidentiality

1._____ 2. _____

3. _____4._____

It is my professional opinion that _____ has the knowledge and skills to safely possess and use an Epi-Pen in school and should be allowed to carry and use that medication by himself/herself without supervision.

Lic. Prescriber's Signature: _____Date: _____

Lic. Prescriber's Name (please print): _____

Business Telephone: _____ Emergency Telephone: _____

PARENT/GUARDIAN AUTHORIZATION

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Yes No I give my permission for release/exchange of pertinent information between the school nurse and the licensed prescriber's office by telephone, mail or electronic exchange regarding all of the above medical/ medication information concerning my child.

Yes No I give my permission for other school personnel to be notified of the medication and any adverse effects.

Signature of Parent/ Guardian_____ Date: _____

My child has been instructed in the proper way to use his/her medications and should be allowed to carry and use that medication by himself/herself without supervision and I give my child permission to do so.

Signature of Parent/ Guardian _____Date: _____