HANOVER PUBLIC SCHOOL DISTRICT
Epi-Pen-Self-Administration By Students

_____ _____ _____
Student's Name Grade Date

To self medicate, the student must be able to: (check all that apply)

____ 1. Respond to and visually recognize his/her name.

____ 2. Identify his/her medication.

____ 3. Demonstrate the proper technique for self-administering his/her medication.

____ 4. Sign his/her medication sheet to acknowledge having taken the medication.

____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

_____ _____ _____
Name of Medication Dosage Frequency

The above named student has demonstrated the ability to self-administer the physician-prescribed Epi-Pen, as indicated by the criteria listed above.

_____ _____
Date Signature (Certified School Nurse)

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the schools bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above medication will result in the immediate confiscation of the Epi-Pen and loss of privilege to self-administer if the medication policy is violated.

_____ _____
Date Parent/Guardian Signature

I agree to be solely responsible for my Epi-Pen and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of the Epi-Pen.

_____ _____
Date Student's Signature

PPS-112 March 2016, June 2020, March 2022