

**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

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: _____

SAU Policy Committee: Adopted – October 15, 2020

Clarksville School Board: Adopted – December 14, 2020

Colebrook School Board: Adopted – December 15, 2021

Columbia School Board: Adopted – January 6, 2021

Pittsburg School Board: Adopted – December 1, 2020

Stewartstown School Board: Adopted – January 12, 2021