**LVISD PERMISSION FOR SELF-ADMINISTRATION OF EPI-PEN**

ON ANY OCCASION THAT STUDENTS MUST CARRY AN EPI-PEN AT SCHOOL, THIS FORM MUST BE COMLETED AND SIGNED IN ADVANCE BY THE STUDENT’S PARENT OR GUARDIAN, STUDENT, AND THE PHYSICIAN. THE FORM MUST BE ON FILE IN THE SCHOOL OFFICE AND THE EPI-PEN MUST BE FURNISHED BY THE PARENT/GUARDIAN.

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STUDENT’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT’S RESPONSIBILITY**

I HEREBY REQUEST THAT OUR CHILD BE ALLOWED TO CARRY AND SELF-ADMINISTER HIS/HER EPI-PEN AS PRESCRIBED BY OUR MEDICAL DOCTOR. I REALIZE THE PRIVILEGE OF SELF-ADMINISTRATION MAY BE REVOKED AT ANY TIME IF MY STUDENT IS NOT HANDLING THE MEDICATION SAFELY.

I ACKNOWLEDGE THAT THE SCHOOL INCURS NO LIABILITY FOR ANY INJURY RESULTING FROM THE SELF-ADMINISTRATION OF MEDICATION TO INDEMNIFY AND HOLD THE SCHOOL, AND ITS EMPLOYEES AND AGENTS, HARMLESS AGAINST ANY CLAIMS RELATING TO THE SELF-ADMINISTRATION OF SUCH MEDICATION.

\* PLEASE NOTE - PLEASE ASK THE PHARAMCIST TO PLACE AN APPROPRIATE LABEL ON THE EPI-PEN ITSELF SO THAT IT IS EASILY IDENTIFIED. EMS WILL BE CALLED FIRST IF THE STUDENT USES THE EPI-PEN AND THEN THE PARENT.

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Printed name of parent/guardian Signature of parent/guardian Daytime phone Date

**STUDENTS RESPONSIBILITY:**

1. I WILL KEEP THE EPI-PEN IN MY POSSESSION AT ALL TIMES.

2. I WILL USE THE EPI-PEN ONLY AS PRESCRIBED BY MY DOCTOR.

3. I WILL NOT SHARE THIS EPI-PEN WITH OTHERS.

4. I WILL IMMEDIATELY REPORT TO SCHOOL STAFF IF I USE THE EPI-PEN.

5. I REALIZE I CAN LOSE THIS PRIVILEGE IF I MISHANDLE MY EPI-PEN.

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Signature of student Date

**PHYSICIAN’S STATEMENT:**

MEDICATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOSE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR MEDICATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BEGIN DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ END DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (limited to one year)

Through my consultation with the above-named student and student’s parents/guardians I have determined that he/she

is able to identify the correct medication, demonstrate correct self-administration of the above-listed medication and has

knowledge of the required dosage and timing/frequency of use of the medication.

The student has knowledge of his/her condition and is sufficiently responsible and able to properly carry and self-administer

the medication during the school day. The student has been instructed in the purpose, appropriate method, and frequency of

use of the medication and is capable of self-administering the medication.

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Physician’s signature Date