

LVISD PERMISSION FOR SELF-ADMINISTRATION OF EPINEPHRINE

ON ANY OCCASION THAT STUDENTS MUST CARRY AN EPINEPHRINE DEVICE AT SCHOOL, THIS FORM MUST BE COMPLETED 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 EPINEPHRINE DEVICE MUST BE FURNISHED BY THE PARENT/GUARDIAN.

STUDENT'S NAME _____

PARENT'S RESPONSIBILITY

I HEREBY REQUEST THAT OUR CHILD BE ALLOWED TO CARRY AND SELF-ADMINISTER HIS/HER EPINEPHRINE DEVICE 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 PHARMACIST TO PLACE AN APPROPRIATE LABEL ON THE EPINEPHRINE DEVICE ITSELF SO THAT IT IS EASILY IDENTIFIED. EMS WILL BE CALLED FIRST IF THE STUDENT USES THE EPINEPHRINE DEVICE AND THEN THE PARENT.

Printed name of parent/guardian

Signature of parent/guardian

Daytime phone

Date

STUDENT'S RESPONSIBILITY:

1. I WILL KEEP THE EPINEPHRINE DEVICE IN MY POSSESSION AT ALL TIMES.
2. I WILL USE THE EPINEPHRINE DEVICE ONLY AS PRESCRIBED BY MY DOCTOR.
3. I WILL NOT SHARE THIS EPINEPHRINE DEVICE WITH OTHERS.
4. I WILL IMMEDIATELY REPORT TO SCHOOL STAFF IF I USE THE EPINEPHRINE DEVICE.
5. I REALIZE I CAN LOSE THIS PRIVILEGE IF I MISHANDLE MY EPINEPHRINE DEVICE.

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.

Physician's signature

Date