FLOSSMOOR SCHOOL DISTRICT 161

PHYSICIAN AUTHORIZATION AND REQUEST FOR SELF-ADMINISTRATION OF EMERGENCY EPINEPHRINE AUTO-INJECTOR MEDICATION (EPI-PEN)

Student Name ______________________ School/Grade ______________________

Birth date ______________________ Address ______________________

Phone Number ______________________ Emergency Contact Person/Phone Number ______________________

Health Condition: ______________________________________
(Diagnosis)

I am requesting that the above-named student take the following medication as prescribed below during school hours (including before or after normal school activities, while in a school-sponsored activity and while under the supervision of school personnel):

Name of Medication Type of Medication

Purpose of Medication

Dosage Time(s) to be Administered

Special Circumstances Under Which Medication to be Administered

Possible Side Effects

I certify that ______________________________ **has been instructed in the use and self-**
(Name of Student)
administration of ______________________________________
(Name of Medication)

He/She understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication independently.

______________________ ______________________
Prescriber's Signature **Date Signed**

______________________ ______________________
Print Name of Prescriber **Prescriber's Emergency Phone #**

____
Prescriber's Address

____

2018-2019

FLOSSMOOR SCHOOL DISTRICT 161
PARENTAL AUTHORIZATION FOR SELF-ADMINISTRATION OF
EMERGENCY EPINEPHRINE AUTO-INJECTOR MEDICATION (EPI-PEN)

STUDENT NAME: ____
(Last) *(First)* *(M.I.)*

BIRTHDATE: ________________________

SCHOOL/GRADE: ___________________

DATE: ______________________________

The following guidelines shall apply to the self-administration of a student's emergency epinephrine auto-injector medication (epi-pen):

1. **Physician/Prescriber signed dated authorization to administer the medication, setting forth the name and purpose of the medication, the prescribed dosage, time for administration and any other special related information to the administration.**

2. **Parent (Guardian) signed, dated authorization to administer the medication.**

3. **The medication is in the original labeled prescription container as dispensed or the manufacturer's labeled container.**

4. **The prescription medication label contains the student name, name of the medication, prescribed dosage, time at which or circumstances under which the medication is to be administered.**

5. **Flossmoor School District 161 and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student.**

I hereby acknowledge that I am the parent and/or legal guardian of the above-referenced student and that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize Flossmoor School District 161 to allow my child to self-administer his or her legally prescribed emergency epinephrine auto-injector medication (epi-pen) during the following: (1) while in school; (2) while at a school-sponsored activity; (3) while under the supervision of school personnel; and (4) before or after normal school activities.

I further acknowledge and agree that Flossmoor School District 161 and its employees and agents are to incur no liability, except for willful and wanton conduct by any of the said parties, as a result of any injury arising from my child's self-administration of emergency epinephrine auto-injector medication (epi-pen). I further acknowledge and agree that, in absence of willful and wanton conduct on the part of Flossmoor School District 161 and its employees and agents, I waive any claims that I might have against said parties arising out of my child's self-administration of said medication. In addition, I agree to indemnify and hold harmless Flossmoor School District 161 and its employees and agents, either jointly or severally, except claims based on willful and wanton conduct on behalf of said parties, from and against any and all claims, damages, causes of action or injuries incurred or resulting from my child's self-administration of said medication.

Signature: ___________________________ ___________________________
Parent/Guardian ***Home Phone***

Date: ________________________________ ___________________________
Cell Phone

FLOSSMOOR SCHOOL DISTRICT 161

STUDENT AGREEMENT TO CARRY
EMERGENCY EPINEPHRINE AUTO-INJECTOR MEDICATION (EPI-PEN**)**

To carry medication, the student must demonstrate the ability to:

State the importance of maintaining safe storage of the medication in school, including carrying medications.

State the importance of not allowing other students to use the medication.

State the name, dosage, and frequency of the medication.

State the purpose/reason/symptom for using the medication.

If your child has an epi-pen prescribed, it is recommended that an extra epi-pen be kept in the school health office in the event that the carried epi-pen is lost.

Student Signature: ______________________________ **Date:** ________________________

Parent/Guardian Signature: ______________________________ **Date:** ________________________