

**Northwestern Local School District
Prescribed EPIPEN Authorization**

Procedure for Keeping an Epipen with the Student who has Anaphylactic reaction

Purpose: To permit students to possess and use a prescribed Epipen during school hours and activities.

Name: _____ Birthdate: _____

School Building: _____ Teacher: _____ Grade: _____

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES AND USES PRESCRIBED EPIPENS IN SCHOOL; BOTH PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to possess and use or have administered to them an Epipen according to the doctor's verification on this form.
2. I will assume responsibility for safe delivery of the Epipen to school either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the Epipen.
4. I release and agree to hold harmless the Board of Education, its officials, and its employees, from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian

Date

Home Telephone

Work Telephone

**PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF
EPIPENS BY STUDENT**

Student: _____ is under my care and should receive _____

_____ at the following time: _____

Specific instructions for administration: _____

Possible side effects to watch for: _____

The student has been instructed in the proper use of the Epipen:	Yes _____	No _____
The student has demonstrated proper use of the Epipen:	Yes _____	No _____
The student is responsible to carry the Epipen with him/her	Yes _____	No _____
The EpiPen is to be kept in the clinic/office area for use:	Yes _____	No _____

Expiration date of this request: _____

A NEW FORM MUST BE COMPLETED FOR EACH CHANGE AND EACH SCHOOL YEAR.

Physician's signature & printed name

Date

Physician's office/emergency phone number