Lubbock-Cooper Independent School District

EPINEPHRINE INJECTOR----------SELF ADMINISTERED
TO BE COMPLETED BY PARENT OR GUARDIAN;

Date: _______________

I hereby give permission for my child, ____, to self-administer his/her prescribed epinephrine in case of an allergic reaction. I also state that my child is capable of self-administering the prescription medication as the physician ordered and storing it in accordance with Lubbock-Cooper ISD Policy. My child understands he/she must seek immediate medical attention after self-administering the prescription medication.

Parent /Guardian Signature: ____

TO BE COMPLETED BY PHYSICIAN:
Date: _______________
Child's Name: ___________________________________ has a history of anaphylaxis and is capable of self-administering the prescribed injection:
Medication and Purpose:
____

____
Prescribed Dosage:
____

____
Time at which or circumstances under which medicine may be administered:
____

____

Dates for which medicine may be administered at school: ______________________________

Dates for which medicine is prescribed: ____

Comments or Special Instructions/adverse reaction:
____
____
____

Physician Name: ____
Signature: ____
Phone: _______________________

BOTH SECTIONS MUST BE COMPLETED AND RETURNED TO THE SCHOOL NURSE BEFORE A STUDENT CAN CARRY MEDICATIN AT SCHOOL.