Permission for Self-Administration of Epinephrine Injector

Student Name: _____ D.O.B. _____ Grade: _____

Epinephrine Brand: _____

Epinephrine Dose: ( ) 0.15mg IM ( ) 0.3 mg IM

Students at Veazie Community School who are known reactors to insect stings or other agents and need to be treated with epinephrine should have access to this medication at all times during an and off campus activities. In order to carry their epinephrine injector, students must demonstrate knowledge of safe use of this medication to physician and school nurse and have written permission of parent, physician, and school nurse.

Please obtain the necessary medication in its original labeled prescription container and sign and return this form. This form will be kept on file at the school. Thank you.

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I REQUEST THAT MY SON/DAUGHTER BE ALLOWED TO CARRY EPINEPHRINE WITH THEM BECAUSE OF A KNOWN ANAPHYLACTIC REACTION. I ASSUME RESPONSIBILITY FOR SUPPLYING THE MEDICATION AND VERIFY THAT MY CHILD HAS BEEN INSTRUCTED ABOUT ITS POPER USE.

Parent Signature: _____ Date: _____

Physician Name (printed): _____

Physician: _____ Date: _____
Signature

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APPROVED BY: School Nurse _____ Date: _____