Genoa-Kingston Community School District #424

980 PARK AVENUE
GENOA, ILLINOIS 60135
PHONE (815) 784-6222 FAX (815) 784-6059

PHYSICIAN REQUEST FOR SELF-ADMINSTRATION / CARRY OF EPIPEN

SCHOOL YEAR _____

SCHOOL _____

Student _____ Date of Birth _____

_____ _____ _____ _____
Address City Zip Contact Number

The above named student has _____ .
Allergy

I am requesting that the above named student carry the following medication during school hours.

_____ _____
Name of Medication Type of Medication

_____ _____
Dosage Time of Administration

_____
Possible Side Effects

I certify that _____has been instructed in the use and
Student's Name

safe transport of _____,
Medication

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

I may be reached at the following telephone number in the event of an emergency:

_____ _____ _____
Signature of Physician Printed Name of Physician Date

_____ _____
Address of Physician Phone Number

Ref: Illinois Department of Human Services and Illinois State Board of Education
"Recommended Guidelines for Medication Administration in Schools"