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)			
	before o	dent take the following medication a or after normal school activities, we pervision of school personnel):			
Name of Medication		Type of Medication			
Purpose of Medication					
Dosage Time(s) to be Administered	1				
Special Circumstances Under Whi	ch Medic	eation to be Administered			
Possible Side Effects					
I certify that(Name of Stration of		has been instructed in	the use and self-		
	(Name	e of Medication)			
		medication and the necessity to He/She is capable of using			
Prescriber's Signature Date Signed			_		
Print Name of Prescriber	_	Prescriber's Emergency Phone #			
Prescriber's Address	-				

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

STUDENT NAME: (Last) (First) (M.I.) BIRTHDATE: (Last) (First) (M.I.) SCHOOL/GRADE: DATE: (M.I.) 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 why child to self-administr 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 seid rempleace and agents, i waive any claims that I might have against said parties arising out of		nt/Guardian	Home 1	Phone	
BIRTHDATE: SCHOOL/GRADE: DATE:	Signature:				
BIRTHDATE:	agents are to incur a result of any inju- injector medication wanton conduct or waive any claims administration of s School District 161 on willful and wan- damages, causes o	no liability, except ary arising from my a (epi-pen). I furth a the part of Floss that I might ha aid medication. In and its employees aton conduct on be	for willful and wanter child's self-administer acknowledge an moor School Districtive against said paraddition, I agree to and agents, either chalf of said parties	on conduct by any of the said pastration of emergency epinephrid agree that, in absence of will be the said arties arising out of my child indemnify and hold harmless Flipointly or severally, except claim, from and against any and all	arties, as ne auto- llful and agents, l d's self- ossmoor ns based l claims
BIRTHDATE:	student and that I in the event that I my child to self-ac medication (epi-per activity; (3) while u	am primarily responsion am unable to do so dminister his or hand during the follow	onsible for administ o, I hereby authorized ter legally prescribed wing: (1) while in	ering medication to my child. It e Flossmoor School District 161 d emergency epinephrine auto school; (2) while at a school-sp	However to allow injector oonsored
BIRTHDATE:	liability	, except for willfu	l and wanton condu	ict, as a result of any injury ai	
BIRTHDATE:	medicat	tion, prescribed do	sage, time at whic		
(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.				scription container as dispens	sed or
(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	2. Parent	Guardian) signed,	dated authorizatio	n to administer the medicatio	n.
(Last) (First) (M.I.) BIRTHDATE: SCHOOL/GRADE: DATE: The following guidelines shall apply to the self-administration of a student's emergency	setting time for	forth the name an r administration a	d purpose of the m	edication, the prescribed dosa	
(Last) (First) (M.I.) BIRTHDATE: SCHOOL/GRADE:				inistration of a student's en	nergency
(Last) (First) (M.I.) BIRTHDATE:	DATE:				
STUDENT NAME: (Last) (First) (M.I.) BIRTHDATE:	SCHOOL/GRADE:		_		
STUDENT NAME: (M.L.)	BIRTHDATE:	(Last)	(First) —	(1/1.1.)	
	STUDENT NAME:	(T 4)	(D: 4)	(7. T.)	

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:	