\_\_\_\_\_MD

 \_\_\_\_\_parent

 \_\_\_\_\_backup

**Lin-Wood Public School**

**Phone: 603-745-2214 Fax: 603- 745-2352**

**Epi-Pen Administration Form (Self administered)**

Student's Name: DOB:

Student's Teacher: Grade:

Parent/Guardian Name: Emergency Tel#

Diagnosis/Condition:

Name of Medication:

DOSE to be given @ school and ROUTE:

FREQUENCY and TIME(s) to be given @ School:

Specific recommendations for administration:

Contraindications, Adverse Reactions and/or Side-effects of this medication:

Severe adverse reactions that may occur to another pupil for whom the epinephrine is not prescribed, should such a pupil receive a dose of the medication:

Dates to be given @ school OR if all year put school year date:

Please list all medications child is taking @ home (prescription and Over-the Counter medications):

It is my professional opinion that has the knowledge and skills to safely possess and use an Epi-Pen in school and should be allowed to carry and use that medication by himself/herself without supervision.

(Circle One) Yes No

Lic. Prescriber's Signature: Date:

Lic. Prescriber's Name (please print):

Business Telephone: Emergency Telephone:

PARENT/GUARDIAN AUTHORIZATION

I, (print name), give my permission for release/exchange of pertinent information between the school nurse and the lic. prescriber's office by telephone, mail or electronic exchange regarding all of the above medical/medication information concerning my child.

(Circle One) Yes No

Signature of Parent/Guardian: Date:

My child has been instructed in the proper way to use his/her medications and should be allowed to carry and use that medication by himself/herself without supervision and I give my child permission to do so.

Signature of Parent/Guardian: Date:

(Circle One) Yes No