Licking Heights Local Schools
Self Medication For Epinephrine Auto-injector Authorization Form

Student Name: _____ Grade: _____
Address: _____
Reason for carrying EpiPen® (Circle one): Bee Sting Peanuts Tree Nuts Other
If circling other, please specify_____
Medication name: _____
Dosage: _____
Date administration is to begin: _____ Date administration is to end: _____
Adverse reactions that should be reported to the physician: _____
_____
Procedure to follow in the event that medication does not produce the expected relief from student's anaphylactic reaction: _____
_____
Other instructions: _____
_____
NOTE: When completing this form a Food Allergy Action Plan filled out by the parent and physician should also accompany the Epinephrine Auto-injector authorization form to assist us with any additional procedures or instructions to ensure the safe care of the student with an allergy while at school.

By signing below the physician or other health care provider and parent/guardian state that it is their request that the child carry the epinephrine auto-injector on their person at school and at school functions; they realize that because the student is self-administering medication, no adult may be aware that the student is experiencing difficulty, preventing adults from responding appropriately in an emergency; and that the child has been fully trained in the use of the epinephrine auto-injector, knows why, how and when to use it properly and will not give the epinephrine auto-injector to any other students.
I understand that emergency medical services (EMS) will always be called when epinephrine is given, whether or not the student manifests any symptoms of anaphylaxis.

Physician name: _____ Phone: _____
Signature: _____ Date: _____

Parent / Guardian name: _____ Phone: _____
Signature: _____ Date: _____

By signing below the student states an understanding of the circumstances of his/her specific allergy, symptoms of severe reaction or anaphylaxis and identifying the need for epinephrine and mastery of technique of administration of EpiPen®. The student agrees to NEVER share the EpiPen® with another person. The student agrees to seek adult help IMMEDIATELY from the school nurse or another adult in the event of exposure to a known allergen (regardless whether or not epinephrine was administered).

Student Signature: _____ Date: _____

In the event that the epinephrine auto-injector is abused or misused by the student or others, school personnel have the responsibility to assume control of the epinephrine auto-injector and contact the parent/guardian to assess the next best action for the student, classmates and others.

Nurse's signature: _____ Date: _____