Deweyville ISD

Permission to Self-Carry an Epi Pen

Student's Name: _____ DOB: _____

The above student has an epi pen and is capable of self-administering the prescription epi pen medication as described below:

Name of Medication: _____

Purpose of Medication: _____

Dosage: _____

Period of time for which medication is prescribed _____

It is advised that a second epi-pen be kept in the school nurse clinic to facilitate rapid treatment.

Physician Signature _____ Phone Number _____

Date: _____

I authorize my child to self-administer his/her prescription epi pen as per doctor orders while on school property or at a school related event or activity. I understand that my child is responsible for the proper handling and carrying of the epi pen and it must be kept out of the reach of other students at all times. The epi pen must have a current prescription label indicating that it has been prescribed for my child. I understand that any misuse of this medication will result in revoking the ability of my child being able to self-carry medication at school and will be considered as a violation of campus drug

policy.

Student Signature _____ Date _____

Parent Signature _____ Date _____