

**Gregory Portland Independent School District
Gregory Portland Health Services**

Permission to Self-Administer or Possess Emergency Anaphylaxis Medication (EpiPen)

School:				Date:
Student:	Last	First	Grade:	ID#
Address:			City:	Zip Code:
Name of Parent/Guardian			Phone #1:	Phone #2
Name of Parent/Guardian			Phone #1:	Phone #2

Rules for Student Possession and/or Administration of Epinephrine (EpiPen):

Entitles a student with asthma or anaphylaxis to possess and/or self-administer prescription anaphylaxis medicine while on school property or at a school-related event or activity under the following conditions:

1. The prescription label shows that the medicine has been prescribed for that student.
2. The self-administration is in compliance with the prescription or written instruction from the student's physician.
3. The student's parent provides the school with written authorization signed by the parent.
4. The student's parent provides the school with a written statement from the physician stating the student is capable of self-administration and/or possessing the medication.
5. If the student is not allowed possession and administration of the medication, this must be clearly stated in writing, as to what will occur.
6. A release to for the school nurse to communicate with the physician may be requested.
7. As with any medication, the medication must be current (not expired on the label), and the physician's prescription to administer must be less than one year.
8. The symptoms of anaphylaxis may reoccur after the use of an EpiPen. EMS will be activated when the EpiPen is utilized.
9. The student will have an Emergency Anaphylaxis Action Plan on file at the Nurse's Office.
10. The form must be updated yearly and kept on file in the nurse's office.

Physician's/ Practitioner's Statement: I, _____ (printed name), state that this student: _____ (printed name of student) is capable of self-administration and or possession of his/her emergency anaphylaxis medication. Please denote the function desired if the student will not be allowed to administer or possess the medication. This authorization is valid for one year.

Name of medication: _____ Dosage: _____ Frequency: _____

Physician's Signature: _____ Date: _____
Emergency Contact Number: _____

This consent may come in the form of a prescription, provided that the name of the physician and an emergency medical phone number is present.

Comments: _____

Parent/Guardian Statement: I, _____ (printed name), parent/guardian of _____ give my permission for my child to self-administer and/or possess his/her emergency anaphylaxis medication (EpiPen) according to the physician's order. I will teach my child that he/she is responsible for possessing the medication. I am also aware that student educational opportunities exist so that my child may learn more about managing their medical condition during the school day.

Parent Signature: _____ Date: _____

Nurse/School Staff only: _____ Date Received: _____

This plan is in effect for the current school year and summer school as needed.