NORTH PENN SCHOOL DISTRICT
AUTHORIZATION TO CARRY/SELF ADMINISTER EPINEPHRINE AUTO INJECTOR

(Student to carry copy of this document at all times. Original to be on file in School Nurse's Office)

FOR PHYSICIAN, CERTIFIED REGISTERED NURSE PRACTITIONER, PHYSICAN'S ASSISTANT USE ONLY
PHYSICIAN, CERTIFIED REGISTERED NURSE PRACTITIONER, PHYSICAN'S ASSISTANT AUTHORIZATION

Student _____ DOB _____ Grade _____

Medication and dose _____

Time of or circumstances requiring self-administration _____

Diagnosis _____

Possible side effects/conditions to observe _____

_____

IN MY OPINION, THIS STUDENT SHOWS THE CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE-NAMED MEDICATION.

(It is preferable that additional prescription labeled medication be kept in the School Nurse's Office in case the first is left at home or lost.)

Duration of authorization (maximum one (1) school year) _____

Physician's signature _____ Date _____

Printed physician's name _____ Phone _____

Address _____

Certified Registered Nurse Practitioner's signature _____ Date _____

Printed Certified Registered Nurse Practitioner's name _____ Phone _____

Address _____

Physician's Assistant signature _____ Date _____

Printed Physician's Assistant name _____ Phone _____

Address _____

FOR STUDENT USE

I have been instructed in the proper use of my prescribed medication and fully understand how and when to use it. I will use this medication only according to the above instructions. I will not share this medication under any circumstances. I understand that, should another student use my medication, or if I misuse the medication, the privilege of carrying my medication with me may be taken away. I will immediately report lost or missing medication. I also agree to come directly to the school nurse, a teacher, a coach, or an athletic trainer after using my medication in order to report its use.

Student's signature _____ Date _____

FOR PARENT/GUARDIAN USE

I request that my child (named above) be permitted to carry/self-administer the above medication as per the order above. I understand that the medication must be in a properly labeled pharmacy container and properly labeled Epinephrine Auto Injector. I understand that I, the parent/guardian, accept the legal responsibility should the above medication be misused, lost, given to, or taken by a person other than the above-named student, and that, as a result, the privilege of carrying the medication may be taken away. I understand that the North Penn School District has no legal responsibility to ensure that the medication is taken or when the above-named student administers his or her own medication and bears no responsibility for the benefits or consequences of the administration of the medication.

Parent/Guardian signature _____ Date _____