

**SELF-MEDICATION REQUEST FORM**  
**(Epinephrine Autoinjectors)**  
**LAKE LOCAL SCHOOL DISTRICT**

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*This portion to be completed by the Parent/Guardian*

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Student Name \_\_\_\_\_

Building \_\_\_\_\_

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School Year \_\_\_\_\_

Grade/Teacher \_\_\_\_\_

Date of Birth \_\_\_\_\_

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Address \_\_\_\_\_

I request that my child be permitted to carry his/her epinephrine autoinjector (Epipen) on his/her person while at school and for school related activities. I realize that my child will be required to have his/her injector on his/her person in order to go on any field trips or other extracurricular events off campus. A back up injector is to be kept in the school clinic. This form is valid for the remainder of this school year or until the prescribing doctor or other authorized healthcare provider discontinues this prescription/dose. I further understand that use of an Epipen will result in a 911 call and a call to the parents/guardians.

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Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Phone (H/W/C) \_\_\_\_\_

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*This portion to be completed by the physician or other prescribing health provider*

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Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Time \_\_\_\_\_

Date administration of the medication is to begin: \_\_\_\_\_ end: \_\_\_\_\_

Adverse reactions that should be reported to the physician: \_\_\_\_\_

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Procedure to follow in the event that the medication does not produce the expected relief from the student's anaphylactic reaction: \_\_\_\_\_

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This student received instruction in the use of this injector by myself or my trained staff. It is my recommendation that this student carry his/her auto injector on his/her person at all times.

Yes      No      (circle one)

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Physician/Authorized Prescribing Healthcare Provider Signature \_\_\_\_\_

Phone \_\_\_\_\_

Date \_\_\_\_\_

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Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_