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

Student Name Building

School Year Grade/Teacher Date of Birth

Address

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

Medication Dosage Time

Date administration of the medication is to begin: ____________________ end: ____________________

Adverse reactions that should be reported to the physician: ____________________

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

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)

Physician/Authorized Prescribing Healthcare Provider Signature *Phone in case of emergency* *Date*

Printed Name *Address* *Telephone in case of emergency*

This portion to be completed by the Parent/Guardian

I request that my child be permitted to carry his/her epinephrine auto injector (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.

Parent/Guardian Signature *Date* *Phone Numbers (Home/Work/Cell) in case of emergency*