# KUTZTOWN AREA SCHOOL DISTRICT

## EPIPEN - AUTHORIZATION FOR SCHOOL MEDICATION ADMINISTRATION

*Child's Name* _____ *Grade* _____

*Allergies:* _____

**Physicians Request**

*Name of prescribed medication:* _____

*Reason:* _____

*Dosage:* _____

*Side Effects:* _____

_____ **I believe this child is able and responsible to carry and self-administer his/her epipen. S/he has permission to do so and has been instructed on how to self-administer.*

_____ ***I believe this child is able and responsible to carry and self-administer the medication during field trips and extra curricular activities. S/he has permission to do so, and has been instructed on how to self-administer.*

*Physician's Signature* _____ *Date* _____

*Physician's phone number* _____

**Parent Request**

*I, the parent/guardian of* _____ *request that the employees (nurse, principal, or principal designee) of Kutztown Area School District allow my child to follow the guidelines as set above by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Kutztown Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the prescribed medication.*

*My wish is for my child to:*

_____*Carry his/her epipen and self-administer as per the physicians order.*

_____*I request the epipen be locked up in the health room with the understanding that there will not be access to the medication other than during the academic school day. In other words, my child may not be able to get to the medication if he/she is having an allergic reaction before or after school hours.*

*Parent Signature* _____ *Date* _____

*List all medications currently being taken by this child:*