

EPINEPHRINE SELF-ADMINISTRATION FORM

Student Name: _____ **B/D** _____ **Student ID** _____

The Missouri Safe Schools Act of 1996 and statute 167.627 provide for students to carry and self-administer life-saving medications when the following criteria are met:

- 1) *Written authorization by the parent/guardian*
- 2) *Written treatment plan/individual healthcare plan on file at school*
- 3) *Written authorization from the prescribing health care provider that child has allergies with a potential for anaphylaxis, has been trained in the use of the medication and is capable of self-administration of the medication.*

MEDICATION NAME _____ **Dose** _____ **Time or Interval** _____

Route _____ **Instructions** _____

MEDICATION NAME _____ **Dose** _____ **Time or Interval** _____

Route _____ **Instructions** _____

ALLERGIES: list known allergies to medications, foods, or air-borne substances _____

I, the parent or legal guardian of the student listed above, give permission for this child to carry and self-administer the above listed medications. I have instructed my child to notify the school staff if he/she is having symptoms of severe allergic reaction and/or has used his/her epinephrine immediately. The epinephrine injection device will be saved and the child will be transported to the hospital for further evaluation either by the parent or by ambulance. I understand that, absent any negligence, the school shall incur no liability as a result of any injury arising from the self-administration of medication by my child.

Signature of parent or legal guardian _____ **Date** _____

Parent/Guardian:

Name: _____ Home phone: _____

Address: _____ Work phone: _____

Name: _____ Home phone: _____

Address: _____ Work phone: _____

Emergency Contact:

Name: _____ Phone: _____

I, a licensed health care provider, certify that this child has a medical history of severe allergies with potential for anaphylaxis, has been trained in the use of the listed medication, and is judged to be capable of carrying and self-administering the listed medication(s). The child should notify school staff if he/she is having symptoms of severe allergic reaction and/or uses the medication. The child will be transported either by the parent or an ambulance with the used injection device for further medical evaluation following its use. The child understands the hazards of sharing medications with others and has agreed to refrain from this practice.

Signature of Health Care Provider _____ **Date** _____

Healthcare Provider:

Name: _____

Fax: _____ Phone: _____

Address: _____ City: _____ Zip: _____