

**BRECKSVILLE-BROADVIEW HEIGHTS CITY SCHOOL DISTRICT**

**PRESCRIBED EPIPEN AUTHORIZATION**

Procedure for Keeping an Epipen with the Student Who has Anaphylactic Reactions

Purpose: To permit students to possess and use a prescribed Epipen during school hours.

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

SCHOOL \_\_\_\_\_ TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_

To the Parent/Guardian:

**THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES AND USES PRESCRIBED EPIPENS IN SCHOOL; BOTH PORTIONS OF THIS FORM MUST BE COMPLETED.**

1. I am requesting permission for the student named above to possess and use an Epipen according to the doctor's verification on this form.
2. I will assume responsibility for safe delivery of the Epipen to school either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the Epipen.
4. I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

\_\_\_\_\_  
Signature of Parent/Guardian Date

Day phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**ALL MEDICATION MUST BE IN ORIGINAL PHARMACY DISPENSED CONTAINERS. LABELS MUST MATCH INSTRUCTIONS FROM DOCTOR ON THIS FORM.**

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**PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF EPIPENS BY STUDENT.**

\_\_\_\_\_ is under my care and should receive \_\_\_\_\_

\_\_\_\_\_ at the following time \_\_\_\_\_.

Specific instructions for administration: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Possible side effects to watch for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The student has been instructed in the proper use of the Epipen - YES \_\_\_\_\_ NO \_\_\_\_\_

The student has demonstrated proper use of the Epipen - YES \_\_\_\_\_ NO \_\_\_\_\_

The student is responsible to carry the Epipen with him/her - YES \_\_\_\_\_ NO \_\_\_\_\_

**A NEW FORM MUST BE COMPLETED FOR EACH CHANGE AND EACH SCHOOL YEAR.**

Prescription beginning date \_\_\_\_\_ Prescription expiration date \_\_\_\_\_

Date form completed \_\_\_\_\_ Physician Signature \_\_\_\_\_

Physician Printed Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Physician Address \_\_\_\_\_

