Epi-Pen
Self –Administration Authorization

Parent/guardian request for permission to self-administer an Epi-Pen and acknowledgement that District Policy 210.1 applies to this signed permission

Student Name & Grade ______________________________

Medication Dosage ______________________________

Reason for Medication ______________________________

This student has received instruction in my office regarding the safe self-administration of the above medication.

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(Physician Signature) (Telephone Number) (Date)

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(Parent/Guardian Signature) (Telephone Number) (Date)

*The student will be evaluated by the Nurse. The parent/guardian and 911 will be called. District Policy 210.1 is available on the District's website at www.wsdweb.org.

M7 Revised 11/2011