BENJAMIN LOGAN LOCAL SCHOOL DISTRICT

AUTHORIZATION FOR THE POSSESSION AND USE OF EPINEPHRINE AUTOINJECTOR (EPI-PEN)

Student Name _____ Date _____

Address _____

Prescriber must acknowledge one of the following (please initial):

The student is capable of possessing and using the autoinjector: Yes___ No___
The student has been trained on the proper use of the autoinjector: Yes___ No___

An additional pen must be available in the building office.

Medication Name _____

Dosage _____

Date the administration is to begin _____

Date the administration is to cease _____

Adverse reactions that should be reported to the physician: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack or other condition requiring emergency medication: _____

_____

_____

Other special instructions: _____

_____

I release and agree to hold the board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent Signature _____ Phone (home) _____

(work) _____

Date _____ (other) _____

PHYSICIAN AND PARENT/GUARDIAN NAMES, SIGNATURES, AND EMERGENCY PHONE NUMBERS ARE REQUIRED.

Physician name _____ Phone _____

Signature _____ Date _____

Copies must be provided to the Principal and to the School Nurse.