**Laconia School District**

**Epi-Pen Authorization**

**Parent/Guardian Authorization for school personnel to administer Epinephrine**

**Name of Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (printed guardian name), am the parent/guardian of the student named above. I have provided to the school an Epi-Pen, namely an emergency-ready injection of epinephrine for the treatment of anaphylaxis for an allergy to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (list allergy). This has been prescribed for the student by a physician.

I permit trained school personnel to be able to administer epinephrine to the student in the event of an emergency. I understand that in the event that the Epi-Pen is administered, Emergency Medical Services will be called and I will be notified.

The school nurse and/or school principal have addressed any questions I have regarding use of the Epi-Pen by school personnel.

**Guardian Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_

Contract between Student, Guardian, Nurse and Doctor for

Permission to Carry Epi-Pen Autoinjector

1. Student has demonstrated to the nurse correct use of the Epi-Pen Autoinjector.

2. Student agrees to never share the Epi-Pen Autoinjector with another person.

3. Student agrees to notify the nurse when the Epi-Pen Autoinjector has been used.

4. Doctor’s order to carry and self-administer Epi-Pen Autoinjector is attached.

5. A spare Epi-Pen Autoinjector will be kept in the Nurse’s Office, in case the student forgets theirs or it runs out.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to carry the Epi-Pen Autoinjector described below. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child’s condition.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Medication) (Dose) (Allergy

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_