YOUR SCHOOL DISTRICT

PARENTAL CONSENT FOR THE ADMINISTRATION OF EPINEPHRINE IN SCHOOL

SECTION 1 - STUDENT INFORMATION				
Student Name: ____				**DOB:** ________________
Building: _________________________		**Grade:** ___________		**Bus #:** ________________
What is your child allergic to?	☐ Dairy	☐ Peanuts	☐ Soy	☐ Other:____________________
	☐ Eggs	☐ Sesame	☐ Sting	☐ Other:____________________
	☐ Fin Fish	☐ Shellfish	☐ Tree Nuts	☐ Other:____________________
3. **Has your child ever been allergy tested?** ☐ Yes ☐ No **If yes, date tested:** ______				

SECTION 2 – PARENTAL CONSENT	
1. **I give permission to the school nurse and the school doctor to discuss treatment of the aforementioned student with the student's physician:** ☐ Yes ☐ No **List doctor's name:** _________________________________	
2. **I give permission to the school nurse or her designee to administer EpiPen/EpiPen Jr to the aforementioned student. I understand that it will be injected into the muscle of his/her leg or arm:** ☐ Yes ☐ No	
3. **Has your child been trained to self-administer EpiPen/EpiPen Jr?** ☐ Yes ☐ No **If yes, how often do you review self-administration?** ____________________________	
4. **I give permission for the aforementioned student to carry his/her EpiPen/EpiPen Jr:** ☐ Yes ☐ No **Where is EpiPen/EpiPen Jr kept?** ____	
In order to ensure that your child will receive this life preserving medicine promptly when indicated, we are obligated to inform appropriate school personnel. Your signature below gives us permission to do so.	
Date: __________	**Parent/guardian Signature:** ____________________________________
Printed Name: ________________________________ **Relationship:** ____________________	
Please note: this permission is valid one year from date of signature.	
Please return this form to: (building, nurse's name, phone, fax)	

SAMPLE