The Lowell School

Dede Proujansky
Executive Director

EPINEPHRINE AUTO INJECTOR (EPIPEN) MEDICATION FORM

Student's Name: _____

_____ My child does not need/use an Epipen.

Parent Signature: _____ Date: _____

HEALTH CARE PROVIDER AUTHORIZATION

The above named student is under my care. I feel it is medically appropriate for the student to self-administer Epinephrine Auto Injector (EPIPEN) medication, when able and appropriate, and be in possession of Epipen medication and supplies at all times. The medication prescribed for this student is:

Name of medication: _____
Dosage: _____
Possible side effects: _____
_____

Signature of Health Care Provider: _____ Date: _____

PARENT AUTHORIZATION

_____ I authorize my child to carry and self-administer the medication described above

_____ I do not authorize my child to carry and self-administer this medication.

_____ I authorize appropriate/designated school personnel to maintain my child's medication prescribed above for use in an emergency.

Parent Signature: _____ Date: _____

AN EPIPEN MUST BE PROVIDED TO THE SCHOOL ON THE FIRST DAY OF THE SCHOOL YEAR.