Request for Self-Administration of Anaphylactic Medication

Health Services

Board of Education policy permits students who have been diagnosed with severe allergic (anaphylactic) reaction and prescribed medication be permitted to carry and administer the medication independently. Documentation from the parent and physician certifying that the student has been instructed in the use and self-administration of the medication must be on file at the school.

This form must be completed, signed by the parent and physician, and submitted to the school office on an annual basis, at the beginning of each school year.

Student's Name: _____ Birth Date: _____ Grade: _____
Please Print

Name of Prescribed Medication: _____

Dosage: _____ Method of Administration: _____

Time or Indication for Administration: _____

Possible Side Affects: _____

*** Is this a controlled drug?** ☐ **YES** ☐ **NO**

I certify that the above named student has been instructed in the use and self-administration of the anaphylactic medication prescribed. I also certify that he/she understands the need for the anaphylactic medication and the necessity to report any unusual side effects that may occur when using the medication at school to school personnel.

Name of Physician: _____ Phone Number: _____
Please Print

Address: _____

_____ _____
Signature of Physician Date

I authorize School District 158 and its employees and agents, to allow my child to possess and use his/her anaphylactic medication: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. I agree to indemnify and hold harmless School District 158 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent's Name: _____ Relationship: _____
Please Print

Home Phone: _____ Work Phone: _____ Cell: _____

Name of Alternate Emergency Contact: _____ Phone: _____

_____ _____
Signature of Parent Date