SEVIER COUNTY BOARD OF EDUCATION

AUTHORIZATION FOR SELF-CARRY/ADMINISTRATION OF EPI-PEN ANAPHYLAXIS MEDICATION AT SCHOOL AND SCHOOL-RELATED ACTIVITIES

Tennessee state law permits a responsible, trained student to carry and/or self-administer medication for severe allergic reaction (anaphylaxis) for use in a life-threatening situation with physician authorization and parent request. This authorization is good only for one school year and must be renewed by the physician each year.

Name_____ DOB_____ School Year_____
School_____ Grade_____ Teacher_____
Reason for medication_____
Name of medication, dose, and administration method_____
Indications for administration_____
Other information_____

PHYSICIAN STATEMENT:
In my opinion, this student shows the capability to ____carry and/or _____self-administer the above medication.

_____	_____	_____	_____
Physician Signature	**Print Physician Name**	**Telephone**	**Date**

PARENT/GUARDIAN AUTHORIZATION:
I request that my child be allowed to: _____carry _____self-administer the above medication. I take responsibility for this permission and agree to the following (indicated by parent initials):

_____I understand that the medication must be in the original container, labeled with name of medication, dosage, directions for use, student name, health care provider name, and date of original prescription. Any leftover medications will be destroyed unless picked up by the last day of the school year.

_____I understand that Emergency Medical Services (911) will be called anytime the Epi-Pen is administered.

_____I understand and agree that in an emergency in which my child is not capable of self-administrating this medication, a trained staff member of the school system may administer the medication to my child.

_____I agree to notify the school immediately of any change in phone numbers, address, doctor, or contacts.

_____I agree to release the school district and its employees from liability for any injury that may arise from the administration of the prescription medication while my child is at school or a school-related activity except in case of wanton or willful misconduct on the part of the school system employee.

_____I do not want my child to be allowed to carry the above medication. I take full responsibility for this decision, realize that I alone am responsible for any harm that may come from my decision, and release the school from all liability.

_____	_____	_____	_____
Parent Signature	**Date**	**Student Signature**	**Date**

PARENT/EMERGENCY CONTACTS:

Name	**Phone#**	**Name**	**Phone#**
_____	_____	_____	_____
_____	_____	_____	_____