

Must Be Completed By The Licensed Prescriber

Authorization for Student Possession and Use of an Epinephrine Auto-Injector (KRS 158.834)

Student Name

Date of Birth

Student Address

This section must be completed and signed by the licensed prescriber.

Diagnosis

Medication

Dosage

Route

Time to be Administered

Date to Begin

Date to End

(or end of school year whichever is first)

Procedures for School Employees if the student is unable to administer the medication or if it does not produce expected relief: _____

Possible Severe Adverse Reactions:

To the student for whom the medication is prescribed: _____

To as student for whom it is NOT prescribed who receives a dose: _____

Special Instructions: _____

Licensed Prescriber's Name

Licensed Prescriber's Signature

Date

Address

Emergency Telephone Number

Fax Number

This section must be completed and signed by the student's parent/guardian.

As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto-injector at school and at any activity, event, or program sponsored by or in which the student's school is a participant as prescribed. I understand that a school employee will immediately call 911 if the medication is administered. Also, **I will provide a back-up dose of the medication to the school clinic as required by law.**

Parent/Guardian Name

Parent/Guardian Signature

Date

For School Use Only

The following student has demonstrated correct use of the epinephrine auto-injector and understanding of self-carry safety issues at school.

The student has also been instructed to inform the nearest school employee ASAP after having administered the epinephrine auto-injector.

Student Signature _____ Date _____

Parent Signature _____ Date _____