

# Saratoga Union School District

"Three Dimensional Success"

20460 Forrest Hills Drive • Saratoga, California 95070

Tel. 408.867.3424 • FAX 408.867.2312 • www.saratogausd.org

## Request for pupil to carry and self-administer Epi-pen

A pupil may carry and self-administer prescription auto-injectable epinephrine (Epi-pen) if the District receives an appropriate written statement from the pupil's physician or surgeon AND his/her parent, foster parent, or guardian. The written statements shall be provided at least annually, and more frequently if there is a change in the pupil's healthcare provider, or if the medication, dosage, frequency or method of or reason for administration changes. *A pupil may be subject to disciplinary action pursuant to Education Code section 48900 if he/she uses auto-injectable epinephrine in a manner other than as prescribed.*

In order for a pupil to carry and self-administer prescription Epi-pen, the pupil must provide **both**:

- A written statement from the physician detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken, and confirming that the pupil is able to self-administer auto-injectable epinephrine.
- A written statement from the parent of the pupil consenting to the self-administration, providing a release for the school nurse or other designated school personnel to consult with the health care provider and pharmacist of the pupil regarding any questions that may arise with regard to the medication, and releasing the District and school personnel from liability if the self-administering pupil suffers an adverse reaction as a result of self-administering the medication.

*The District has the right to prevent the student from self-administering medications any time the above conditions are not met or it determines the student cannot safely or responsibly administer the medication.*

### **To be Completed by Parent / Foster Parent / Guardian and Student:**

I give my consent for exchange of information between the healthcare provider listed below, the pharmacist dispensing the medication, and the Saratoga Union School District.

I represent that my child has been instructed in the proper dosage and administration of epinephrine and has demonstrated the ability to self-administer it. I give permission for my child's self-administration of prescription auto-injectable epinephrine at school and school-related activities and events. I understand that it is my responsibility to keep all prescriptions current, and to update this form as needed. I agree that I will never commence, cause, maintain, or prosecute any action against the Saratoga Union School District based upon any claims, demands, causes of action, obligations, or liabilities of any kind whatsoever related to my child's self-administration of prescription auto-injectable epinephrine. I release the Saratoga Union School District, its employees, agents, and board members from any and all liability in connection with my child's self-administration and any adverse reaction that may result from his/her administration of this medication or failure to administer the medication.

Student Name \_\_\_\_\_

Parent/foster parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**Student Certification:** I certify that I have read and understand the instructions regarding the self-administration of my medication. I agree to take my medication in compliance with my healthcare provider's recommendations and instructions and with District rules.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

**To be Completed by Physician:**

Date of prescription \_\_\_\_\_ Dates to be administered at school \_\_\_\_\_

Name of medication \_\_\_\_\_ Method of administration \_\_\_\_\_

Dosage to be administered \_\_\_\_\_ Time to be administered \_\_\_\_\_  
(If to be administered on an as-needed basis, please explain how and when medication is to be given)

Pupil able to self-administer auto-injectable epinephrine (where applicable): Yes \_\_\_\_\_ No \_\_\_\_\_

Additional information or precautions \_\_\_\_\_

Physician Signature \_\_\_\_\_ Name (please print) \_\_\_\_\_

Phone number \_\_\_\_\_ Address \_\_\_\_\_