Written Authorization for Self-Administration of EpiPens or any Epinephrine Auto-injectors By Minor Students at Fellowship Christian School

Student Name: _______________________________________ Date of Birth: ___________________ Grade: ______

I, __________________________________, parent/legal guardian of the above named student hereby request authorization for self-administration and possession of an EpiPen or any other epinephrine auto-injectors by this student while in school, at a school sponsored activity, while under supervision of school personnel, and while in before-school or after-school care on school operated property. The student demonstrates full understanding of the proper use of his/her allergy medication.

I understand that:

- Fellowship Christian School (FCS) and its employees and agents shall incur no liability for: a) any injury to the student caused by his or her administration of medication except for injury caused by willful or wanton misconduct; b) the student's use, misuse, overuse, or neglected or failed use of his or her allergy medication; and c) lost, misplaced, outdated, inaccessible, empty, or faulty allergy medication and allergy devices.
- FCS may choose to require supervision of medication administration in the event that the student does not demonstrate appropriate use or proper technique with allergy medication.
- FCS has the authority to enforce rules and consequences for inappropriate behavior demonstrated by the student in association with the possession and/or self-administration of allergy medication and that the school has the authority to require supervision of medication use as deemed appropriate for the safety of all students and staff.

I take sole responsibility for:

- the monitoring of allergy medication, medication use, and refilling of prescriptions for allergy medication as the school will not be responsible for the supervising, recording, and monitoring of self-administered allergy medication.
- ensuring the student always carries his/her allergy medication on his/her person.
- deciding if back up medication will be kept at the school and providing the school with the back-up medication.
- informing the school staff in writing of any changes in the student's treatment or allergy management.
- informing the school of any allergy exacerbations, hospital visits, and/or new or changed student medical information.
- informing school staff in writing of any medication side effects that warrant communication to the parent/guardian.
- coordinating distribution of the student's allergy management and emergency plan to school staff (school health worker, teachers, physical educators, coaches, bus drivers, before-school and after-school staff).

I understand and agree to the conditions of the school policy. I permit the school to seek emergency medical treatment for the student when deemed necessary and appropriate. I accept legal responsibility should the medication be misused or given or taken by a person other than the above named student. I release Fellowship Christian School and its employees and agents of any legal responsibility related to the above named student's possession and self-administration of his/her allergy medication.

____ ____

Parent/Legal Guardian Signature Date

I, __________________________________, (the above named student) have been instructed in the proper use of my prescription allergy medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstance. I understand and agree to the terms of the school policy.

____ ____

Student Signature Date

The above named student has been instructed and demonstrates understanding of the proper use of his/her allergy medication. It is my professional opinion that the student be permitted to carry and self-administer his/her allergy medication. I have provided the parent/guardian with a written allergy emergency/management plan including the name, purpose, dosage, and administration directions of the allergy medication.

____ ____

Healthcare Provider Signature Date

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