WAYLAND PUBLIC SCHOOLS

PARENT/GUARDIAN PERMISSION FOR ADMINISTRATION OF EPINEPHRINE (EPI-PEN) BY UNLICENSED SCHOOL PERSONNEL IN THE ABSENCE OF THE SCHOOL NURSE

Student's Name:_____ DOB:_____

Address:_____ Grade:_____

Parent/Guardian Name:_____

Home Phone:_____ Other Phone(s):_____ _____

If Parent/Guardian is unavailable in emergency, contact:

Name:_____

Phone(s):_____ _____

Relationship to student:_____

My son/daughter has the following allergy(s) which may require treatment with epinephrine (Epi-pen), according to my child's physician: _____

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CONSENT FOR TREATMENT

I give permission to allow the administration of epinephrine by auto-injection (Epi-pen) by the school nurse or, in the absence of the school nurse, by an unlicensed member of the school staff who has been trained and delegated by the school nurse to my son/daughter, in the event of an emergency. I also allow the school nurse to share with appropriate school personnel information relative to this medication administration plan.

_____ _____

Signature of Parent/Guardian **Date**

Q:Schools\FormsII\Consent Epi-pen Program