

PARIS UNION SCHOOL DISTRICT NO. 95

REQUEST FOR CARRYING & SELF-ADMINISTRATION OF EPI-PEN  
(epinephrine auto-injector)

Student's Name \_\_\_\_\_ School \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ Allergies \_\_\_\_\_

TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER:

Medication Name/Dosage \_\_\_\_\_ Time \_\_\_\_\_ Route \_\_\_\_\_

Disease/illness of student \_\_\_\_\_

Action of drug \_\_\_\_\_

Side effects of drug \_\_\_\_\_

Other Medications Child Is Receiving? \_\_\_\_\_

To be given until what date? \_\_\_\_\_

\_\_\_\_\_  
Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

I am prescribing the above medication to be used by the above named student and I certify the student/parent has been instructed in the proper use and care of his/her inhaler. I further understand I will be notified by the school district if the student abuses or misuses the privilege per Public Act #094-0792.

\_\_\_\_\_  
Physician/Nurse Practitioner Signature Phone Number Date

\_\_\_\_\_  
District Nurse Initials Date

The above named medication is to be brought to school in a container appropriately labeled by the pharmacy or physician. Please return completed form to school and give to the school secretary or nurse.