Santa Cruz Valley Unified School District # 35
Authorization for Administration of Epi-Pen

Student's Name: (First, MI, Last) ________________________________

Sex: (please circle) Female Male Date of Birth: ___________

School:________________________________

FOR COMPLETION BY THE PARENT/GUARDIAN

Mother's Name: ___________________________________

Father's Name: ___________________________________

Mother's Work phone: _______________ Father's Work phone: ________________

Home Telephone: __________________ Emergency phone: __________________

Physician's Name: __________________ Physician's Phone :__________________

I hereby authorize my child to carry and self-administer the Epi-Pen. I have instructed my child NOT to make available, provide, or give the item to another student. My child will immediately report the loss or theft of this medication. My child is aware that misuse of this medication subjects him/her to disciplinary action. In addition, I have counseled my child that if the auto-injectable epinephrine is self-administered, this action is to be reported to the Health Office immediately.

Parent/Guardian Signature: ______________________ Date: _________________

Comments:____
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