SAINT IGNATIUS COLLEGE PREP

SELF-ADMINISTRATION OF ALLERGY MEDICINE/EPI PEN PERMISSION FORM

Policy Statement for Saint Ignatius College Prep

Dear Parent/Guardian,

State Law requires that we inform the parents/guardian of the student, in writing, that the school and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of allergy medication by the student.

The permission for self-administered allergy medication is effective for the school year for which it is granted and must be renewed each school year. A student with allergies or other medical condition may possess and use his/her medication while in school, at school-sponsored activities, while under the supervision of school personnel, or before or after regular school activities. We recommend that you provide an additional dose of medication to be kept at school in the event that your child forgets or loses the medication.

READ, SIGN BELOW AND RETURN THIS FORM TO DEANS' OFFICE.

I,_____Parent/Guardian of _____

acknowledge that Saint Ignatius College Prep and its employees and agents are to incur no liability, except in willful and wanton conduct, as a result of any injury arising from the self-administration of allergy medicine by the above named student. I indemnify and hold harmless Saint Ignatius and its employees and agents against any claims arising out of self-administration of allergy medication by the student.

SIGNED:_____ DATE:_____

I give permission for my child to carry allergy medication/Epi pen as ordered by his/her physician. I will notify the school of changes in medication or my child's condition.

Parent/Guardian Signature:_____ Date:_____

_____ _____

Name of Student **Date of Birth**

_____ _____

Address **City** **Zip** **Phone**

PHYSICIAN'S ORDERS: (To be completed by student's physician)

The above named student has _____

I request that the student self-administer the following medication during school hours.

Medication:_____

Dose:_____Frequency:_____

Possible Side Effects:_____

I certify that the above named student has been instructed in the use and self-administration of this medication. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Physician's Printed Name:_____ Phone:_____

Signature of Physician:_____ Date:_____