

**PRINCETON REGIONAL SCHOOL DISTRICT
Princeton, New Jersey**

Self-Medication for Allergic Reaction

Date: _____

Since your child has a severe allergy, it may be necessary for him/her to carry medication to counteract an allergic episode. Please complete this form and return it to your child's school nurse by

_____.

_____ (student's name) has been instructed in the proper use of his/her EPI-PEN for allergic episodes.

We, this child's parent/guardian and his/her physician, request that _____ (student's name) be permitted to carry on his/her person. He/she has been instructed in and understands the purpose, appropriate method, and frequency of the use of this medication. We consider him/her to be responsible.

Medication: _____

We, the undersigned, absolve the school of any responsibility in safeguarding our child's medication (EPI-PEN).

This request will terminate automatically when medication is completed or at the end of the school year and at the discretion of the school nurse.

Parent/Guardian

Health Care Provider

NOTE: This form must be completed in addition to the medication form required of any student needing medication during school hours/activities, including class trips.

Health Care Provider Stamp or Printed Name: _____

This portion of the form has been completed by the school nurse.

Student's Name

Demonstration Date

School Nurse

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