City of St. Charles R-6 School District
400 N. Sixth St., St. Charles, MO 63301

PERMISSION FOR STUDENT TO SELF-ADMINISTER MEDICATION
By Pre-measured Epinephrine Self-Injection Device
(EpiPen ® or Twinject Auto-injector®)

Building: _____ Phone: _____

Contact: _____ Fax: _____ School Year _____

I hereby certify the following:

1. I, _____, am the parent or legal guardian of _____ ("Student"), a student in the St. Charles School District ("District"), and am legally authorized to make educational and health care decisions for the Student.
2. I hereby give my permission for the Student to retain in his/her possession a pre-measured Epinephrine self - injection device and to self-administer medication from such device. This permission shall be effective during the school day; on school property, including but not limited to a school bus; and at all school activities, whether on or off school property or occurring during the regular school day.
3. I have provided the District with a written medical history of the Student's experience of anaphylaxis and a plan of action for addressing any emergency situations that could reasonably be anticipated as a consequence of administering the medication and having the Condition.
4. I have provided the District with written certification from the Student's physician, stating that the Student (a) has the aforementioned Condition and (b) is capable of, and has been instructed in, the proper method of self-administration of medication and informed of the dangers of permitting other persons to use the medicine prescribed for the Student.
5. I understand the District and its employees or agents my disclose information provided in accordance the foregoing paragraphs to administrators, school nurses, teachers, and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-administer medication by means of EpiPen® or Twinject® device, and shall incur no liability for the disclosure of such information.
6. I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medication by the Student, and that I shall be required to indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administration of medication by the Student.
7. I understand that this permission for is effective for the school year for which it is granted, and that a new Permission Form and supporting documentation as described above, must be submitted for each school year.

_____ _____

Date Date Received by Nurse

_____ _____

Signature of Parent/Guardian Signature of School Nurse