# San Francisco Unified School District – School Health Programs, SFCSD

## MEDICATION FORM for Epinephrine Auto Injector

Dear Parent/Guardian/Caregiver:
California Education Code 49423 provides that students required to take medically prescribed or over-the-counter medications during the school day **MAY** be assisted by school personnel **ONLY** if the school district receives a specific written statement from the health care provider **AND** the parent/guardian/caregiver of the student. **Please complete this entire form and return it to the Principal.**

**P l e a s e p r i n t l e g i b l y i n a l l s e c t i o n s**

| Student Name: Last | First | Middle | Date of Birth (Month/Day/Year) |
|---|---|---|---|
| | | | |

## HEALTH CARE PROVIDER SECTION

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|---|---|
| **Health Condition for which medication is prescribed:**<br>Severe Allergic Reaction to the following: | **Medication:** Please circle<br>EpiPen EpiPen Jr.<br>Dose: ☐ 0.15 mg ☐ 0.3 mg<br>Other Epinephrine Auto-Injector:_____<br>Dose:_____<br>Frequency:_____ |
| **Symptom of Severe Allergic Reaction include:** * can be life-threatening!<br>Mouth: itching, swelling of lips/tongue<br>Throat*: itching, tightness/closure, hoarseness<br>Skin: itching, hives, redness, swelling<br>Gut: vomiting, diarrhea, cramps<br>Lung*: shortness of breath, cough, wheeze<br>Heart*: weak pulse, dizzy, passing out | |
| **Medication Route:** Injection to outer thigh | **Time medication to be given at school?** As needed |
| **The medication is to be given:**<br>-If suspicion of exposure to the source of allergy AND at least one symptom<br>-Any life-threatening symptom | **Any precautions that school personnel need to know? Contraindications?** |
| **What are possible side effects of the medication?**<br>Increased heart rate, dizziness, shakiness, paleness, weakness, anxiety, headache | **What should be done after administering Epinephrine?**<br>Call 911 after administering medication and give used auto-injector to paramedics to bring to ER with student |
| **Check appropriate boxes below:**<br>☐ **I authorize this student to self-administer the above medication.**<br>☐ **I authorize designated school personnel to administer the above medication.** | |
| **Print name, address & phone number of Health Care Provider** | **Signature of Health Care Provider** **Date** |

## PARENT / GUARDIAN / CAREGIVER SECTION

| | | | | |
|---|---|---|---|---|
| Parent/Guardian/Caregiver Name | | | Home Language | Daytime Phone ( ) |
| Address – Number and Street | Apt No. | City | Zip Code | Evening Phone ( ) |
| School | | | Pre-K/ Elementary / Middle / High | Grade |

Check appropriate boxes below:
- ☐ I permit my child to give himself/herself the above medication.
- ☐ I permit designated school personnel to give my child the above medication.

1. I agree to hold the San Francisco Unified School District (SFUSD) and its employees harmless from any and all liability for the results of taking the medication or the manner in which the medication is given.
2. I will reimburse the SFUSD and its employees for any liability arising out of these arrangements.
3. I will notify the Principal of the school immediately if there is a change in my child's medication.
4. I understand it is my responsibility to send the medication to school in the **original pharmacy container** labeled with my child's name and the health care provider's instructions.
5. I understand that this form automatically expires at the end of each school year.
6. I give my consent for school authorities to take appropriate action for the safety and welfare of the above named child.

**Parent/Guardian/Caregiver Signature** _____ **Date**_____