

EpiPen Self Possession
Mount Pleasant Area School District

In accordance with the Pennsylvania Department of Health, students with epilepsy are permitted to possess and use their own diabetes medication and monitoring equipment, with **written authorization from the student's health care practitioner and parent or guardian and written acknowledgment from the school nurse that the student has demonstrated the capability to self-administer medication.** This provision may be revoked or restricted due to noncompliance, and the school entity shall then ensure the medication and monitoring equipment is readily accessible to the school nurse or other identified and trained school employee in the student's building.

I understand that carrying an Epinephrine Auto Injector requires the following responsibilities:

- The family provides appropriate documentations according to the Mount Pleasant Area School District Medication Guidelines.
- The Student will carry the EpiPen to ensure availability at all times.
- Administration of the EpiPen is the responsibility of the student, following the prescribed medical orders.
- The student will report to the school nurse immediately following the use of the EpiPen for an assessment.
- The student does not share or make available the use of the asthma inhaler and the medication to any other person.

I hereby release the Mount Pleasant Area School District and all its employees from any and all liability for damages our child may suffer as a result of the of this request. I acknowledge that the school nurse bears no responsibility for insuring that the medication is taken as prescribed by the licensed professional. This privilege will be revoked if school policies are abused or ignored. I give permission for my child to self carry all medications and supplies and I, along with my child agree to all adhere to the Mount Pleasant Area School District's Medication Guidelines.

Parental Signature

Date: _____

Student Signature

Date: _____

In accordance with the Pennsylvania Department of Health, I acknowledge that the student has demonstrated the capability to self-administer all diabetic medications. I have reviewed the Licensed Professional orders and give my written authorization for the above student to self carry.

School Nurse Signature

Date: _____